Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Dental Program (Adults/Children)

Billing Instructions

(WAC 388-535)

Copyright Disclosure

About this publication

This publication supersedes all previous MAA Dental Billing Instructions and the following Numbered Memoranda:

02-96 MAA and 03-24 MAA

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http://maa.dshs.wa.gov/ select *Billing Instructions/Numbered Memoranda*.

Important Contacts

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment
Toll-Free (866) 545-0544

Where do I send my dental bills?

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Who do I call to request free in-office provider training?

Field Services Unit
(360) 725-1024
(360) 725-1027
(360) 725-1022
(360) 725-1023

Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

Go to MAA's website at:
http://maa.dshs.wa.gov
Click on "Provider Publications/Fee Schedules."

Where do I call if I have questions on…

Policy, payments, denials, general questions regarding claims processing, or Healthy Options?

Medical Assistance Customer Service
Toll-free 1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Internet billing?
http://maa.dshs.wa.gov
[Open the "Electronic Claims Submission" link in left hand Table of Contents]

Where do I write to get prior authorization?

Program Management &
Authorization Section-Dental Program
PO Box 45506
Olympia WA 98504-5506

For procedures that do not require Radiographs - Fax: (360) 725-2123
On-line update 9/16/04

Definitions

This section contains definitions of words and phrases that the Department of Social and Health Services (DSHS) uses in these billing instructions. MAA also used dental definitions found in the current American Dental Association's Current Dental Terminology and the current American Medical Association's Physician's Current Procedural Terminology. **Where there is any discrepancy between the current CDT or CPT and this section, this section prevails.**

Adult – For the general purposes of MAA's dental program, means a client 21 years of age and older. (MAA's payment structure changes at age 19, which affects specific program services provided to adults or children). [WAC 388-535-1050]

American Dental Association (ADA) – The ADA is a national organization for dental professionals/dental societies.

Anterior - Teeth and tissue in the front of the mouth.

(1) Mandibular anterior teeth - incisors and canines: Permanent teeth 22, 23, 24, 25, 26, and 27; Primary teeth M, N, O, P, Q and R; and
(2) Maxillary anterior teeth - incisors and canines: Permanent teeth 6, 7, 8, 9, 10, and 11; Primary teeth C, D, E, F, G, and H.

Asymtomatic – Having or producing no symptoms. [WAC 388-535-1050]

Authorization - An official approval for action taken for or on behalf of an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by the Medical Assistance Administration (MAA) that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base metal – Dental alloy containing little or no precious metals. [WAC 388-535-1050]

Behavior Management – Managing the behavior of a developmentally disabled client or a client 18 years of age or younger to facilitate the delivery of dental treatment with the assistance of one additional dental professional staff. [WAC 388-535-1050]

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service when the rate for that service is not included in MAA's published fee schedules. Upon request, the provider must submit a "report" which describes the nature, extent, time, effort, and/or equipment necessary to deliver the service. [WAC 388-535-1050]

Caries – Tooth decay through the enamel or decay of the root surface. [WAC 388-535-1050]

Child – For the general purposes of the MAA dental program, means a client 20 years of age or younger. (MAA's payment structure changes at age 19, which affects specific program services provided to children or adults.)

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - Field offices of the Department of Social and Health Services located in communities throughout the state which administer various services of the department at the community level.

Comprehensive oral evaluation – A thorough evaluation and recording of a client's dental and medical history to include: extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening. [WAC 388-535-1050]

Conscious sedation - A drug-induced depression of consciousness during which clients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is maintained. [WAC 388-535-1050]

Core build-up – Refers to building up of clinical crowns, including pins.

Core Provider Agreement - A basic contract that MAA holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Coronal – The portion of a tooth that is covered by enamel, and is separated from the root or roots by a slightly constricted region, known as the cemento-enamel junction. [WAC 388-535-1050]

Crown – A restoration covering or replacing the major part, or the whole of, the clinical crown of a tooth. [WAC 388-535-1050]

Current Dental Terminology - A systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA). [WAC 388-535-1050]

Current Procedural Terminology (CPT™) – A description of medical procedures and is available from the American Medical Association of Chicago, Illinois. [WAC 388-535-1050]

Decay – A term of caries or carious lesion and means decomposition of the tooth structure. [WAC 388-535-1050]

Deep sedation – A drug-induced depression of consciousness during which a client cannot be easily aroused, ventilatory function may be impaired, but the client responds to repeated or painful stimulation. [WAC 388-535-1050]

Division of Developmental Disabilities (DDD) - The division within DSHS responsible for administering and overseeing services and programs for clients with developmental disabilities.

Endodontic - Disease and injuries to the pulp requiring root canal therapy and related follow-up. [WAC 388-535-1050]

EPSDT – The department's early and periodic screening, diagnosis, and treatment program for clients 20 years of age and younger as described in chapter 388-534 WAC. [WAC 388-535-1050]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Flowable Composite – A low viscosity resin that is used in cervical lesions and other small, low stress bearing restorations. [WAC 388-535-1050]

Fluoride varnish or gel – A substance containing dental fluoride, applied to teeth. [WAC 388-535-1050]

General anesthesia – A drug-induced loss of consciousness during which clients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Clients may require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. [WAC 388-535-1050]

High noble metal – A dental alloy containing at least 60% pure gold. [WAC 388-535-1050]

Limited oral evaluation – An evaluation limited to a specific oral health condition or problem. Typically a client receiving this type of evaluation has a dental emergency, such as trauma or acute infection. [WAC 388-535-1050]

Limited Visual Oral Assessment – A screening of the hard and soft tissues in the mouth. [WAC 388-538-050]

Major bone grafts – A transplant of solid bone tissue(s). [WAC 388-535-1050]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs. Also known as Title XIX.

Medical Assistance Administration (MAA) - The administration within the department of social and health services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification (ID) card – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically necessary - See WAC 388-500-0005.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

b) "Part B" is the supplementary medical insurance benefits (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other services and supplies not covered under Medicare Part A. [WAC 388-500-0005]

Minor bone grafts – A transplant of nonsolid bone tissue(s), such as powdered bone, buttons, or plugs. [WAC 388-535-1050]

Noble metal – A dental alloy containing at least 25% but less than 60% pure gold. [WAC 388-535-1050]

Oral hygiene instruction – Instruction for home oral hygiene care, such as tooth brushing techniques or flossing. [WAC 388-535-1050]

Oral prophylaxis – The preventive dental procedure of scaling and polishing that includes removal of calculus, soft deposits, and plaque, and stains from teeth and tooth implants. [WAC 388-535-1050]

Partials or partial dentures – A removable appliance replacing missing teeth in one arch, and receiving its support and retention from both the underlying tissues and some or all of the remaining teeth. See WAC 388-525-1240 for specific information. [WAC 388-535-1050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated);
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY);
c) First five letters of the last name (and spaces if the name is fewer than five letters); and
d) Alpha or numeric character (tiebreaker).

Periodontal maintenance – A procedure for clients who have previously been treated for periodontal disease and starts after completion of active (surgical or nonsurgical) periodontal therapy. It includes removal of the supra and subgingival microbial flora and calculus from teeth and tooth implants. [WAC 388-535-1050]

Periodic oral evaluation – An evaluation performed on a patient of record to determine any changes in the client's dental or medical status since a previous comprehensive or periodic evaluation. This includes a periodontal scaling at least once per year. [WAC 388-535-1050]

Periodontal scaling and root planing - Instrumentation of the crown and root surfaces of the teeth or tooth implants to remove plague, calculus, microbial flora, and bacterial toxins. [WAC 388-535-1050]

Posterior - Teeth and tissue towards the back of the mouth.

(1) **Mandibular posterior teeth** – molars and premolars: **Permanent teeth** 17, 18, 19, 20, 21, 28, 29, 30, 31, and 32 and **Primary teeth** K, L, S, and T.
(2) **Maxillary posterior teeth** – molars and premolars: **Permanent teeth** 1, 2, 3, 4, 5, 12, 13, 14, 15, and 16, and **Primary teeth** A, B, I, and J.

Provider or provider of service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical [dental] care, goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Proximal – The surface of the tooth near or next to the adjacent tooth. [WAC 388-535-1050]

Reline – To resurface the tissue side of a denture with new base material or soft tissue conditioner in order to achieve a more accurate fit. [WAC 388-535-1050]

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration, that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Root canal - The portion of the pulp cavity inside the root of a tooth and the chamber within the root of the tooth that contains the pulp. [WAC 388-535-1050]

Root canal therapy - The treatment of disease and injuries of the pulp and associated periradicular conditions. [WAC 388-535-1050]

Root planing – A procedure to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin on the root surfaces and pockets, or tooth implants. [WAC 388-535-1050]

Scaling – A procedure to remove plaque, calculus, and stain deposits from tooth surfaces, including tooth implants. [WAC 388-535-1050]

Sealant – A material applied to teeth to prevent dental caries. [WAC 388-535-1050]

Simple extraction – Routine removal of tooth structure. [WAC 388-535-1050]

Spenddown – The amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirements.

Standard of care – What reasonable and prudent practitioners would do in the same or similar circumstances. [WAC 388-535-1050]

Symptomatic – Having symptoms (e.g., pain, swelling, and infection). [WAC 388-535-1050]

Tempormandibuar joint dysfunction (TMJ/TMD) – An abnormal functioning of the tempormandibular joint or other areas secondary to the dysfunction. [WAC 388-535-1050]

Therapeutic pulpotomy – The surgical removal of a portion of the pulp (inner soft tissue of a tooth), to retain the healthy remaining pulp. [WAC 388-535-1050]

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill MAA. [WAC 388-535-1050]

Washington Administrative Code (WAC) Codified rules of the State of Washington.

Wisdom Teeth – Teeth 1, 16, 17, and 32.

Xerostomia – A dryness of the mouth. [WAC 388-535-1050]

Dental Program

What is the purpose of the Dental Program?

The purpose of the Dental Program is to provide quality dental and dental-related services to eligible medical assistance clients.

Becoming a DSHS dental provider [Refer to WAC 388-535-1070(1)]

The following providers are eligible to enroll with the Medical Assistance Administration (MAA) to furnish and bill for dental-related services provided to eligible medical assistance clients:

- Persons currently licensed by the state of Washington to:
  - ✓ Practice dentistry or specialties of dentistry;
  - ✓ Practice as dental hygienists;
  - ✓ Practice as denturists; and/or
  - ✓ Administer anesthesia by:
    - ➢ Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;
    - ➢ Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a Certified Registered Nurse Anesthetist (CRNA) under WAC 246-817-180;
    - ➢ Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the Department of Health (DOH) that is current at the time the billed service(s) is provided; or
    - ➢ Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.
  - ✓ Practice medicine and osteopathy for:
    - ➢ Oral surgery procedures; or
    - ➢ Providing fluoride varnish under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

- Facilities that are:

  - ✓ Hospitals currently licensed by DOH;
  - ✓ Federally-qualified health centers (FQHCs);
  - ✓ Medicare-certified ambulatory surgery centers (ASCs);
  - ✓ Medicare-certified rural health clinics (RHCs); or
  - ✓ Community health centers (CHCs).

- Participating local health jurisdictions; and

- Bordering city and out-of-state providers of dental-related services who are qualified in their states to provide these services.

> ☞ **Note:** MAA pays licensed providers participating in the MAA Dental Program for only those services that are within their scope of practice.
> [Refer to WAC 388-535-1070(2)]

Oral and Maxillofacial Surgery

[Refer to WAC 388-535-1070 (3)]

For the dental specialty of oral and maxillofacial surgery:

- MAA requires a dentist to:

  - ✓ Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and
  - ✓ Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

    - ➢ The dentist must have participated for at least three years in a maxillofacial residency program; and
    - ➢ The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.

- A dental provider who meets the above requirements must bill MAA with appropriate Current Dental Terminology (CDT) codes or Current Procedural Terminology (CPT®) codes for services that are identified as covered in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda.

Enrolled dental providers who do ***not*** meet the above conditions must bill MAA using **ONLY** the CDT codes for services that are identified in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda. MAA does ***not*** reimburse for billed CPT codes when the dental provider does not meet these conditions.

Client Eligibility

Who is eligible? [Refer to WAC 388-535-1060]

Clients presenting DSHS Medical Identification cards with the following medical program identifiers are eligible for covered dental services subject to the restrictions and specific limitations listed in the dental fee schedule:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
LCP-MNP	Limited Casualty Program/ Medically Needy Program
MNP-QMB	Medically Needy Program – QMB
GA-U **No out of state care**	General Assistance Unemployable *(Limited coverage – see page D.8 for children or E.8 for adults*
General Assistance **No out of state care**	Alcohol and Drug Abuse Treatment and Support Act (ADATSA) *(Limited coverage – see page D.8 for children or E.8 for adults)*

Are clients enrolled in an MAA managed care plan eligible for services under MAA's Dental Program?

[Refer to WAC 388-535-1060(3)]

Yes! Clients who are enrolled in an MAA managed care plan are eligible for MAA-covered dental services that are not covered by their plan.

Clients who are enrolled in an MAA managed care plan should have a Health Maintenance Organization (HMO) identifier in the HMO column on their Medical ID card.

Clients eligible for enhanced services

Clients of the Division of Developmental Disabilities (DDD) may be entitled to more frequent services. See page D.6.

These individuals will have an "XX" in the "DD" column of their Medical ID card. Individuals lacking the DD information on their Medical ID card are not eligible for the additional services. If you believe that a patient may qualify for these services, refer the individual or the patient's guardian to the nearest Developmental Disabilities Office (see list below).

Division of Developmental Disabilities Field Offices

Region 1
1611 West Indiana Ave
MS: B32-28
Spokane WA 99205-4221
(509) 456-2893
(509) 456-4256 FAX
1-800-462-0624

Region 2
1002 N. 16th Avenue
MS: B39-7
Yakima WA 98909-2500
(509) 225-7970
(509) 575-2326 FAX
1-800-822-7840

Region 3
840 N. Broadway
Building A, Suite 100
MS: N31-11
Everett, WA 98201-1296
(425) 339-4833
(425) 339-4856 FAX
1-800-788-2053

Region 4
1700 East Cherry Street
MS: N46-6
Seattle WA 98122-4695
(206) 568-5700
(206) 720-3334 FAX
1-800-314-3296

Region 5
1305 Tacoma Avenue S., Suite 300
MS: N27-6
Tacoma WA 98402
(253) 593-2812
(253) 597-4368 FAX
1-800-248-0949

Region 6
Airdustrial Park, Bldg. 6
MS: 45315
PO Box 45315
Olympia, WA 98504-5315
(360) 753-4673
(360) 586-6502 FAX
1-800-339-8227

If you have any problems contacting these field offices, call Connie Mix-Clark DDD state office, at (360) 725-3455 or email at clarkcl@dshs.wa.gov.

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Coverage for Children

When does MAA pay for covered dental-related services for children? [Refer to WAC 388-535-1080(1)]

MAA pays for covered dental and dental-related services for children listed in this section **only** when they are:

a) Within the scope of the eligible client's medical care program;
b) Medically necessary;
c) Within the standard of care; and
d) Within accepted dental or medical practice procedures that are:

   i. Consistent with a diagnosis of dental disease or condition; and
   ii. Reasonable in amount and duration of care, treatment, or service.

Items and services are subject to the specific limitations listed in the children's fee schedule.

What dental services are covered for children?

[Refer to WAC 388-535-1080(2)]

MAA covers the following dental-related services:

a) Medically necessary services for the identification of dental problems or the prevention of dental disease (subject to the limitations in these billing instructions).

b) **Oral health evaluations and assessments**, which must be documented in the client's file according to WAC 388-502-0020 and WAC 246-817-310, as follows:

   i. MAA allows a **comprehensive oral evaluation** once per provider as an initial examination, and it must include

      A. An oral health and development history;
      B. An assessment of physical and oral health status; and
      C. Health education, including anticipatory guidance.

   ii. MAA allows a **periodic oral evaluation** once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.

iii. MAA allows a **limited oral evaluation** only when the provider performing the limited oral evaluation is not providing pre-scheduled dental services for the client. The limited oral evaluation must be:

(A) To provide limited or emergent services for a specific dental problem; or
(B) To provide an evaluation for a referral.

c) **Radiographs**, as follows:

i. Intraoral (complete series, including bitewings), allowed – once in a three-year period;
ii. Bitewings, total of four allowed every 12 months; and
iii. Panoramic, for oral surgical and orthodontic purposes only, as follows:

(A) Not allowed with an intraoral complete series; and
(B) Once in a three-year period, except for preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery.

d) **Topical application of fluoride** (either gel or varnish, but not both) for clients through age 18 (additional applications require prior authorization), up to three times in a 12-month period.

e) **Sealants**, once per tooth in a three-year period for:

i. The occlusal surfaces of:

(A) Permanent teeth 2, 3, 14, 15, 18, 19, 30, and 31 only; and
(B) Primary teeth A, B, I, J, K, L, S, and T only.

ii. The lingual pits of teeth 7 and 10.
iii. Teeth with no decay.

f) **Prophylaxis treatment,** which is allowed:

i. Once every 6 months for children age 8 through 18;
ii. Only as a component of oral hygiene instruction for children through age 7; and
iii. For clients of the Division of Developmental Disabilities, see page D.6.

g) **Space** maintainers, for children through age 18 only, as follows:

i. Fixed (unilateral type), one per quadrant;
ii. Fixed (bilateral type), one per arch; and
iii. Recementation of space maintainer, once per quadrant or arch.

h) **Amalgam or composite restorations,** once in a two-year period for the same surface of the same tooth.

i) **Crowns,** as described on page D.26.

j) **Restoration of teeth and maintenance of dental health** as follows:

i. Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration, and are reimbursed as such.

For example:
- MO restoration and a DO restoration on the same tooth must be billed as an MOD, except for teeth 2, 3, 14, and 15.
- MOB restoration and a DO restoration on the same tooth must be billed as an MODB, except for teeth 2, 3, 14, and 15.
- MOL restoration and a DO restoration on the same tooth must be billed as an MODL, except for teeth 2, 3, 14, and 15.
- Buccal and Lingual grooves must not be billed separately.

ii. Proximal restorations that do not involve the incisal angle in the anterior teeth are considered to be a two surface restorations, and are reimbursed as such.

k) **Endodontic (root canal) therapies** for permanent teeth except for wisdom teeth;

l) **Therapeutic pulpotomies**, once per tooth, on primary teeth only;

m) **Pulp vitality test**, as follows:

i. Once per day (not per tooth);
ii. For diagnosis of emergency conditions only; and
iii. Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.

n) **Periodontal scaling and root planing**, as follows:

i. See page D.6 for clients of the Division of Developmental Disabilities;
ii. Only when the client has radiographic evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis.
iii. Once per quadrant in a 24-month period; and
iv. Not allowed when performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

o) **Periodontal maintenance**, as follows:

i. Allowed for 0-18 years old only if clients of the Division of Developmental Disabilities (see page D.6).
ii. Only when the client has radiographic evidence of periodontal disease. There must be supporting documentation, including complete periodontal charting and a definitive periodontal diagnosis.
iii. Once per full mouth in a 12-month period; and
iv. Not allowed when performed on the same date of service as prophylaxis, periodontal scaling, gingivectomy, or gingivoplasty.

p) **Complete and partial dentures** (subject to the limitations on pages D.34-D.36, and necessary modifications, repairs, rebasing, relining, and adjustments of dentures (includes partial payment in certain situations for laboratory and professional fees for dentures and partials.

MAA covers:

i. One set of dentures per client in a ten-year period, with the exception of replacement dentures which may be allowed as specified on page D.35; and
ii. Partials as specific in on page D.34, once every five years.

q) **Complex orthodontic treatment** for severe handicapping dental needs as specified in MAA's *Orthodontic Services Billing Instructions* (visit http://maa.dshs.wa.gov select *Billing Instructions/Numbered Memoranda*).

r) **Occlusal orthotic appliance** for temporomandibular joint disorder (TMJ/TMD) or bruxism one in a two-year period.

s) **Medically necessary** oral surgery when coordinated with the client's managed care plan (if any). See Section F for covered CPT codes for oral surgeons only.

t) **Dental services or treatment necessary for the relief of pain and infections**, including removal of symptomatic wisdom teeth. MAA does not cover routine removal of asymptomatic wisdom teeth without justifiable indications.

u) **Behavior management** for clients through age 18 only, whose documented behavior requires the assistance of one additional dental professional staff to protect the client from self-injuring during treatment. See page D.6 for client of the Division of Developmental Disabilities.

v) **Nitrous oxide for children** through age 18 only, when medically necessary. See page D.6 for clients of the Division of Developmental Disabilities.

w) **Professional visits**, as follows:

i. Bedside call at a nursing facility or residence when requested by the client or the client's surrogate decision maker as defined in WAC 388-97-055, or when a referral for services is made by the attending physician, the director of nursing, or the nursing facility supervisor, as appropriate, allowed once per day (not per client and not per facility), per provider.
ii. Hospital call, including emergency care, allowed once per day.

x) **Palliative (emergency) treatment** of dental pain and infections, minor procedures, which is:

i. Allowed once per client, per day.
ii. Reimbursed only when performed on a different date from:

A. Any other definitive treatment necessary to diagnose the emergency condition; and
B. Root canal therapy.

Note: May be billed in combination with Limited Oral Evaluations and necessary diagnostic radiographs.

iii. Reimbursed only when a description of the service provided is included in the client's record.

What additional dental-related services are covered for DDD clients? [Refer to WAC 388-535-1080(3)]

For clients of the Division of Developmental Disabilities, MAA allows additional services as follows:

a) One of the following teeth cleaning services or combination of teeth cleaning services, subject to the limitations listed:

   i. Prophylaxis or periodontal maintenance, three times per calendar year;
   ii. Periodontal scaling and root planning, two times per calendar year;
   iii. Prophylaxis or periodontal maintenance, two times per calendar year, and periodontal scaling and root planning, two times per calendar year.

b) Gingivectomy or gingivoplasty;
c) Nitrous oxide; and
d) Behavior management that requires the assistance of one additional dental professional staff.

What dental-related services are covered when provided in a non-office setting? [Refer to WAC 388-535-1080(4)]

Providers who bill using CDT codes for the services below must obtain Prior Authorization from MAA. See page D.13.

MAA covers dental services that are medically necessary and provided in a non-office setting (e.g., short stay, ambulatory surgery centers) under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page D.10; and
c) A hospital call, including emergency care, allowed one per day, per client, per provider.

What dental-related services are covered when provided in a hospital? [Refer to WAC 388-535-1080(4)]

Nonemergent oral surgeries performed in an inpatient setting are noncovered. Exceptions to this policy are evaluated for DDD clients whose surgery cannot be performed in an office setting or for medically necessary reconstructive surgery. Exceptions require prior written authorization for the inpatient hospitalization.

When is IV conscious sedation or general anesthesia covered under MAA's Dental Program? [Refer to WAC 388-535-1080(5)]

MAA covers anesthesia for medically necessary services as follows:

a) The anesthesia must be administered by:

   i) An oral surgeon;
   ii) An anesthesiologist;
   iii) A dental anesthesiologist;
   iv) A Certified Registered Nurse Anesthetist (CRNA); or
   v) A general dentist who has a current conscious sedation permit from the Department of Health (DOH).

b) MAA pays for anesthesia services according to WAC 388-535-1350.

What dental-related services are covered for clients residing in nursing facilities or group homes? [Refer to WAC 388-535-1080(6)]

For clients residing in nursing facilities or group homes:

a) Dental services must be requested by the client or a referral for services made by:

   - the attending physician;
   - the director of nursing or the nursing facility supervisor; or
   - the client's legal guardian.

b) A bedside call at a nursing facility or group home is allowed once per day, per provider (regardless of the number of clients seen).

c) Mass screening for dental services of clients residing in a facility is not permitted; and

d) Nursing facilities must provide dental-related necessary services according to WAC 388-97-012 (Nursing facility care).

What are the coverage limits for dental-related services provided under state-only funded programs?

[Refer to WAC 388-535-1120]

As stated on page C.1, under "Clients eligible for limited services," clients who receive services under the following state-only funded programs receive only the limited coverage described below:

MAA covers the dental services described and limited in this billing instruction and under chapter 388-535 WAC for clients eligible for GA-U or GA only when those services are provided as part of a medical treatment for:

a) Apical abscess verified by clinical examination, and treated by:

   i. Open and drain palliative treatment;
   ii. Tooth extraction; or
   iii. Root canal therapy.

b) Cysts or tumor therapies;

c) Maxillofacial fracture;

d) Total dental extraction performed prior to and because of radiation therapy for cancer of the mouth;

e) Sequestrectomies;

f) Systemic or presystemic cancer, only for oral hygiene related to those conditions; or

g) Tooth fractures (limited to extraction).

See next page for list of procedure codes covered under this program.

GA-U/GA Covered Procedure Codes:

ADA	11646	21044	40806
D0140	12001	21045	40808
D0220	12002	21076	40816
D0230	12004	21077	40819
D0330	12005	21141	40831
D3310	12011	21142	41000
~~D3320~~	12013	21143	41005
~~D3330~~	12015	21336	41006
D7111	12016	21337	41007
D7140	12031	21344	41008
D7210	12032	21346	41009
D7220	12034	21347	41010
D7230	12035	21348	41015
D7240	12051	21355	41016
D7241	12052	21356	41017
D7250	12053	21360	41018
D9110	12054	21365	41108
D9220	12055	21366	41825
D9420	13131	21385	41827
D9630	13132	21406	41830
	13133	21407	41874
	13150	21408	42106
CPT	13151	21421	42180
11044	13152	21422	42182
11100	13153	21423	42200
11101	13160	21436	42205
11440	14040	21445	42210
11441	20220	21453	42220
11442	20520	21462	42225
11443	20670	21465	42227
11444	21025	21470	42235
11446	21030	21480	42280
11640	21031	21550	42281
11641	21032	30580	
11642	21034	30600	
11643	21040	40800	
11644	21041	40801	

Billing Procedures

1. The major procedure and all ancillary services must be billed as one treatment plan. Ancillary services will not be considered separately.

2. MAA may require reports and/or radiographs to make an authorization determination. In your request for prior authorization, be sure to include a written justification in *field 35* of the ADA claim form. Remember to mark any radiographs you send with your name and provider number.

   For detailed instructions on how to complete an **ADA claim form**, refer to Section H.

3. Submit the original claim *(make sure the client's PIC is on the claim)*, and any necessary authorization documentation. When MAA returns the original to you, look at the Dental Consultant section for the authorization number and any pertinent comments by the Dental Consultant.

What dental-related services are not covered for children?

[Refer to WAC 388-535-1100(1)(2)]

MAA does not cover the following dental-related services unless the services are:

a) Required by a physician as a result of an EPSDT screen as provided under chapter 388-534 WAC; or
b) Included in an MAA-waivered program

MAA does **not cover** the following services for children:

a) Any services specifically excluded by statute.

b) **More costly services** when less costly, equally effective services as determined by the department are available;

c) Services, procedures, treatments, devices, drugs, or application of associated services that the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the services were provided.

d) **Routine fluoride treatments** (gel or varnish) for clients age 19 through 20 unless the clients are:

   i. Clients of the Division of Developmental Disabilities (see page D.10);
   ii. Diagnosed with xerostomia, in which case the provider must request prior authorization.

e) **Crowns**

i. For wisdom teeth;
ii. Laboratory processed crowns for posterior teeth;
iii. Temporary crowns, including stainless steel crowns placed as temporary crowns; and
iv. Post and core for crowns.

f) **Root canal services** for primary or wisdom teeth;

g) **Root planing**, unless they are clients of the Division of Developmental Disabilities (see page D.6);

h) **Bridges**;

i) **Transitional or treatment dentures**;

j) **Teeth implants**, including follow-up, maintenance;

k) **Cosmetic treatment or surgery**, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

l) **Porcelain margin extensions** (also known as crown lengthening), due to receding gums;

m) **Extraction of asymptomatic teeth**;

n) **Minor bone grafts**;

o) **Nonemergent oral surgery** performed in an inpatient hospital setting, except for the following:

i. For clients of the Division of Developmental Disabilities (see page D.6), or for children 18 years of age or younger whose surgeries cannot be performed in an office setting. This requires written prior authorization for the inpatient hospitalization; or
ii. As provided under "What dental services are covered when provided in a non-office setting," see page D.6.

p) **Dental supplies** such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners;

q) **Dentist's time** writing prescriptions or calling in prescriptions or prescription refills to a pharmacy;

r) **Educational supplies**;

s) **Missed or cancelled appointments**;

t) **Nonmedical equipment**, supplies, personal or comfort items or services;

u) **Provider mileage** or travel costs;

v) **Service charges** or delinquent payment fees;

w) **Supplies used in conjunction with an office visit**;

x) **Take-home drugs**;

y) **Teeth whitening**; or

z) **Restorations for anterior or posterior wear** with no evidence of decay.

Requests for Noncovered Service
MAA evaluates a request for any service that is listed as noncovered under the provisions of WAC 388-501-0165.
[WAC 388-535-1100(3)]

Authorization

Prior Authorization and expedited prior authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.

When do I need to get prior authorization?

Authorization must take place before the service is provided.

Authorization is based on the establishment of medical necessity as determined by MAA. When prior authorization is required for a service, MAA considers these requests on a case-by-case basis. MAA denies a request for dental services when the requested service is:

- Not medically necessary; or
- A service, procedure, treatment, device, drug, or application of associated service which the Department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date of service is provided.

When MAA authorizes a dental-related service for children, that authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. MAA may require second opinions and/or consultations before authorizing any procedure. Authorization is valid only if the client is eligible for covered services on the date of service. [WAC 388-535-1220]

In an acute emergency, the department *may* authorize the service after it is provided when the department receives justification of medical necessity. This justification must be received by MAA within three business days of the emergency service.

MAA authorizes requested services that meet the criteria in the "What dental services are covered for children" section.

Which services for children require prior authorization?

[Refer to WAC 388-535-1220]

The following services require prior authorization:

1) Nonemergent inpatient hospital dental admissions;
2) Crowns (see page D.26);
3) Dentures (see page D.34); and
4) Selected procedures identified by MAA and published in its current dental billing instructions.

The Dental Fee Schedule indicates which services require prior authorization. In the Prior Authorization column:

No	=	Prior Authorization for these services is not required. However, the service must be provided in accordance with the policies indicated for each procedure.
Yes	=	Prior Authorization is required for these services.

How do I obtain written prior authorization?

[Refer to WAC 388-535-1220]

MAA requires a dental provider who is requesting prior authorization to submit sufficient, objective, clinical information to establish medical necessity.

The request must be submitted in writing on a completed ADA Claim Form and include the following:

- The client's patient identification code (PIC);
- Provider's name and address;
- Provider's telephone number (including area code); and
- Provider's assigned 7-digit MAA provider number.

Also…

- Physiological description of the disease, injury, impairment, or other ailment;
- Radiographs;
- Treatment plan;
- Study model, if requested; and
- Photographs, if requested.

(Refer to Section H, How to Complete the ADA Claim Form.)

If MAA approves your request, the ADA Dental Claim Form will be returned to you with an authorization number. **This original form** is to be completed and submitted for payment. Keep a copy for your records.

Where should I send requests for prior authorization?

Mail your request to:

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs
Fax: (360) 725-2123 **On-line update 9/16/04**

☞ **Note**: Include return fax number on all faxed requests for prior authorizations.

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Dental services that are listed as **"Requires Expedited Prior Authorization"** in the fee schedule must have the assigned EPA number for that procedure on the ADA Claim Form when billing. By placing the appropriate EPA number on the ADA Claim Form when billing MAA, dental providers are verifying that the EPA criteria for that procedure code have been met.

Once the EPA criteria are met, use the nine-digit EPA number listed next to the procedure code in the fee schedule.

☞ **Note:** Dental providers are reminded that these unique EPA numbers are ONLY for the procedure codes listed in the fee schedule as "Requires Prior Authorization."

Dental Fee Schedule for Children

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT)
Column 2: Description/Limitations
Column 3: Prior Auth? Is prior authorization required?
Column 4: Maximum Allowable – Children 0 through 18 years of age.
Column 5: Maximum Allowable – Adults 19 through 20 years of age.

- Always bill your usual and customary fee(s) (not MAA's maximum allowable amount).

- For certain procedures, there are separate reimbursement rates for children (0 through 18 years of age) and clients (19 through 20 years of age). These are indicated in the maximum allowable column in the fee schedule.

Remember: You may bill only after services have been provided, but we must* receive *your bill within 365 days from the date of service.

Unless otherwise specified, MAA uses the descriptions of the ADA codes as listed in the CDT manual.

Diagnostic

Clinical Oral Evaluations

HRSA does **not** pay separately for chart or record set-up. The fees for these services are included in HRSA's reimbursement for Comprehensive Oral Evaluations (D0150) and Limited Oral Evaluations (D0140).

Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0120	**Periodic oral evaluation** A periodic evaluation is allowed once every six months. A comprehensive examination must precede a periodic oral evaluation by at least six months.	No	See Appendix	See Appendix
D0140	**Limited oral evaluation** An evaluation limited to a specific oral health problem. A limited examination may also be billed when providing an evaluation for a referral. May not be billed when any prescheduled dental service is provided on the same date- except for palliative treatment and radiographs, necessary to diagnose the emergency condition.	No	See Appendix	See Appendix
D0150	**Comprehensive oral evaluation** An initial evaluation allowed once per client, per provider, per clinic and must include: i. A complete dental and medical history and a general health assessment; ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.	No	See Appendix	See Appendix

Limited Visual Oral Assessment

This procedure code requires expedited prior authorization. (See page D14 for information on the Expedited Prior Authorization process.)

A limited visual oral health assessment does not replace an oral evaluation by a dentist.

Procedure Code	Description/Limitations	EPA Number	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D9999	**Limited visual oral assessment** **EPA Criteria** When billing for this code (D9999) and placing the **assigned EPA number 870000998** onto the ADA claim form, a dental provider is verifying that one of the following occurred: • An assessment was made to determine the need for sealants to be placed by a dental hygienist; • Triage services were provided; • A public health dental hygienist performed an intraoral screening of soft tissues to assess the need for prophylaxis, sealants, fluoride varnish, or referral for other dental treatments by a dentist; or • In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment. This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the parent or guardian of the results. **Refer to page D.15 for information on Expedited Prior Authorization.**	Yes 870000998	See Appendix	See Appendix

Radiographs

Doing both a panoramic film and an intraoral complete series is not allowed.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D0210	**Intraoral – complete series** (including bitewings) A complete intraoral series consists of 14 periapicals and one series of 4 bitewings. Complete series radiographs will be allowed only once in a 3-year period.	No	See Appendix	See Appendix
D0220	**Intraoral periapical – single, first film**	No	See Appendix	See Appendix
D0230	**Intraoral periapical – each additional film**	No	See Appendix	See Appendix
D0240	**Intraoral – occlusal, film**	No	See Appendix	See Appendix
When billing D0270 and D0272 on the same date of service, HRSA's total reimbursement amount will not exceed the reimbursement for D0274.				
D0270	**Bitewing – single film** Total of 4 bitewings allowed every 12 months.	No	See Appendix	See Appendix
D0272	**Bitewings – 2 films** Total of 4 bitewings allowed every 12 months	No	See Appendix	See Appendix
D0274	**Bitewings – 4 films** Total of 4 bitewings allowed every 12 months.	No	See Appendix	See Appendix
D0321	**Temporomandibular joint film**	No	See Appendix	See Appendix
D0330	**Panoramic film – maxilla and mandible** Allowable for oral surgical purposes only. Not to be used for restoration diagnostic purposes. Documentation must be entered in the client's file. Panoramic-type films are allowed once in a 3-year period. A shorter interval between panoramic radiographs may be allowed for: • Emergent services, with authorization from HRSA within 72 hours of the service; **Continued next page.**	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
	• Oral surgical with written prior authorization from HRSA; • Orthodontic services (see HRSA's *Orthodontic Services* Billing Instructions); or • Preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery.			

Test and Laboratory Examination

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D0460	**Pulp vitality test** • Allowed one time per day (not per tooth); • For diagnosis of emergency conditions only; and • Not allowed when performed on the same date as any other procedure, with the exception of an emergency examination or palliative treatment.	No	See Appendix	See Appendix
D0501	**Histopathologic examination** Histological examination of oral hard/soft tissue.	No	See Appendix	See Appendix

Preventive

Prophylaxis (Scaling and coronal polishing)

- No additional allowance will be given for a cavitron or ultrasonic scaling.
- Prophylaxis and topical application of fluoride must be billed separately.
- Not allowed when performed on the same date of service as periodontal scaling or gingivectomy.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1110	**Prophylaxis - adult [age 19-20]** Allowed once every 12 months. Prophylaxis for DD clients allowed three times in 12 months.	No	See Appendix	See Appendix
D1120	**Prophylaxis – child [age 8-18]** Allowed once every six months. Prophylaxis for DD clients allowed three times in 12 months.	No	See Appendix	See Appendix
D1330	**Oral hygiene instructions [child age 0-7]** Allowed once every six months. Includes prophylaxis.	No	See Appendix	See Appendix

Fluoride Treatments

- Fluoride treatments are not covered as a routine adult service for persons 19-20 years of age. This service requires prior authorization for this age group, unless provided to a DDD client.
- Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1203	**Topical application of fluoride [gel or varnish] (prophylaxis not included) – child [age 0-18]** Allowed up to three times in a 12-month period. Additional applications may be reimbursed **with prior authorization**.	No	See Appendix	See Appendix
D1204	**Topical application of fluoride (prophylaxis not included) – adult [age 19-20 for xerostomia only].** Allowed up to three times in a 12-month period.	Yes	See Appendix	See Appendix

Other Preventive Services

- Sealants may be applied to occlusal surfaces of primary and permanent maxillary and mandibular first and second molars and lingual pits of teeth 7 and 10.
- Only teeth with no decay will be covered.
- Sealants are restricted to children 0 through 18 years of age.
- The application of pit and fissure sealants will be covered only once per tooth in a 3-year period.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1351	**Topical application of sealants – per tooth** Tooth and surface designations required. Includes glass ionomer sealants.	No	See Appendix	See Appendix

Space Maintenance

Space maintainers will be allowed as follows:

- To hold space for missing first and/or second primary molars. Space maintainers are allowed for maintaining positioning for permanent teeth for spaces A, B, I, J, K, L, S and T for clients 18 years of age and younger.
- No additional allowance will be given on a lingual arch space maintainer for 3 teeth.
- No reimbursement will be allowed for removing retainers.
- Vertical space maintainers are not covered.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D1510	**Space maintainer - fixed – unilateral** Allowed only once per quadrant. Quadrant designation required.	No	See Appendix	See Appendix
D1515	**Space maintainer – fixed – bilateral** Allowed only once per arch. Arch designation required.	No	See Appendix	See Appendix
D1550	**Recementation of space maintainer** Allowed once per quadrant or arch. Quadrant or arch designation required.	No	See Appendix	See Appendix

Restorative

Amalgam Restorations (including polishing)

- Multiple restorations involving the same surface of the same tooth are considered as a single surface and are reimbursed as such.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a multisurface restoration and are reimbursed as such.
- Reimbursement for all pit restorations is allowed as though for one surface amalgam.
- Bases and polishing amalgams are included in the allowance for the major restoration.
- Amalgams and resin-based composite restorations are covered only once in a 2-year period. This applies only to the same surface of the same tooth. If this surface is redone with an additional adjoining surface, all restored surfaces will be covered. Replacement within a 2-year period requires written justification on claim form and in patient record.
- Amalgam and/or resin build-ups are included in reimbursement for crowns.
- HRSA does not cover flowable composites as a restoration.

Procedure Code	Description/Limitation	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2140	**Amalgam – 1 surface, primary or permanent** Tooth and surface designations required.	No	See Appendix	See Appendix
D2150	**Amalgam – 2 surfaces, primary or permanent** Tooth and surface designations required.	No	See Appendix	See Appendix
D2160	**Amalgam – 3 surfaces, primary or permanent** Tooth and surface designations required.	No	See Appendix	See Appendix
D2161	**Amalgam – 4 or more surfaces, primary or permanent** Tooth and surface designations required.	No	See Appendix	See Appendix

Resin-Based Composite Restorations (Composite/Glass Ionomer)

Proximal restorations that do not involve the incisal angle in the anterior tooth are considered to be a one or two-surface restoration.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D2330	**Resin-based composite – 1 surface, anterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2331	**Resin-based composite – 2 surfaces, anterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2332	**Resin-based composite – 3 surfaces, anterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2335	**Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)** Tooth and surface designations required.	No	See Appendix	See Appendix
D2390	**Resin-based composite crown, anterior** Tooth designation required.	No	See Appendix	See Appendix
D2391	**Resin-based composite – 1 surface, posterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2392	**Resin-based composite – 2 surface, posterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2393	**Resin-based composite – 3 surfaces, posterior** Tooth and surface designations required.	No	See Appendix	See Appendix
D2394	**Resin-based composite, 4 or more surfaces, posterior** Tooth and surface designations required.	No	See Appendix	See Appendix

Crowns for Children

Use the final seating date, not the preparation date, as the date of service.

Crowns not requiring prior authorization

[WAC 388-535-1230(1)]

- The Health and Recovery Administration (HRSA) covers the following crowns for children **without prior authorization**:

  - ✓ Stainless steel. HRSA considers these as permanent crowns, and does not cover them as temporary crowns; and

  - ✓ Nonlaboratory resin for primary anterior teeth.

Crowns that require prior authorization

Laboratory Processed Crowns

[WAC 388-535-1230(2)(3)]

- HRSA requires prior authorization for the following crowns, which are limited to **single** restorations for permanent anterior maxillary and mandibular teeth 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, and 27:

  - ✓ Resin (laboratory);
  - ✓ Porcelain with ceramic substrate;
  - ✓ Porcelain fused to high noble metal;
  - ✓ Porcelain fused to predominantly base metal; and
  - ✓ Porcelain fused to noble metal.

- HRSA does not cover laboratory-processed crowns for posterior teeth.

Radiographs are required by HRSA for confirmation that the requested service meets criteria.

Criteria for crowns

[WAC 388-535-1230(4)(5)]

- Criteria for covered crowns as described on the previous page is:

  - ✓ Crowns may be authorized when the crown is medically necessary.

  - ✓ Coverage is based upon a supportable five-year prognosis that the client will retain the tooth if the tooth is crowned. The provider must submit the following client information:

    - ➢ The overall condition of the mouth;
    - ➢ Oral health status;
    - ➢ Client maintenance of good oral health status;
    - ➢ Arch integrity; and
    - ➢ Prognosis of remaining teeth (prognosis of remaining teeth must not be more involved than periodontal case type II).

  - ✓ Anterior teeth must show traumatic or pathological destruction to loss of at least one incisal angle.

- The laboratory-processed crowns described on the previous page are covered:

  - ✓ Only when a lesser service will not suffice because of extensive coronal destruction, and treatment is beyond intracoronal restoration;
  - ✓ Only once per permanent tooth in a five-year period;
  - ✓ For endodontically treated anterior teeth only after satisfactory completion of the root canal therapy. Post-endodontic treatment radiographs must be submitted for prior authorization of these crowns.

Note: Endodontic treatment alone is not justification for authorization of a crown.

Reimbursement for crowns

[WAC 388-535-1230(6)]

HRSA reimburses only for the covered crowns listed in this section. The reimbursement is full payment. All of the following are included in the reimbursement and must not be billed separately:

- Tooth and soft tissue preparations;
- Amalgam or resin build-ups;
- Temporary crowns;
- Cement bases;
- Insulating bases;
- Impressions;
- Seating; and
- Local anesthesia.

Temporary crowns are included in HRSA's total reimbursement for crowns. HRSA does not reimburse separately for temporary crowns.

Prior authorization is required for all but one of the following crowns. Payment will be denied for claims not having prior authorization. Temporary crowns are included in HRSA's total reimbursement for crowns. HRSA does not reimburse separately for temporary crowns.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2390	**Resin-based composite crown, anterior** Tooth designation required.	No	See Appendix	See Appendix
D2710	**Crown – resin (laboratory)** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2740	**Crown – porcelain/ceramic substrate** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2750	**Crown – porcelain fused to high noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2751	**Crown – porcelain fused to predominantly base metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix
D2752	**Crown – porcelain fused to noble metal** Tooth designation required. Covered for upper & lower permanent anterior teeth only.	Yes	See Appendix	See Appendix

Other Restorative Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D2910	**Recement inlay** Tooth designation required.	No	See Appendix	See Appendix
D2920	**Recement crown** Tooth designation required.	No	See Appendix	See Appendix
D2930	**Prefabricated stainless steel crown – primary tooth** Tooth designation required.	No	See Appendix	See Appendix
D2931	**Prefabricated stainless steel crown – permanent tooth** Tooth designation required.	No	See Appendix	See Appendix
D2933	**Prefabricated stainless steel crown with resin window** Covered for upper anterior primary teeth C through H only. Tooth designation required.	No	See Appendix	See Appendix
D2950	**Core buildup (including pins)** Tooth designation required.	Yes	See Appendix	See Appendix

Endodontic

Pulpotomy (excluding final restoration)

D3220	**Therapeutic pulpotomy** Covered only as complete procedure, once per tooth. **For primary teeth only.** Tooth designation required.	No	See Appendix	See Appendix

Root Canal Therapy

- Includes clinical procedures and follow-up care.
- Separate charges are allowable for open and drain and for root canal treatments if the procedures are done on different days.
- **Not covered for primary teeth.**

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3310	**Anterior (excluding final restoration)** Tooth designation required.	No	See Appendix	See Appendix
D3320	**Bicuspid (excluding final restoration)** Tooth designation required.	No	See Appendix	See Appendix
D3330	**Molar (excludes final restoration)** Tooth designation required. Not covered for wisdom teeth.	No	See Appendix	See Appendix

Endodontic Retreatment

These three codes are not payable to the provider who did the initial root canal. The provider performing the service(s) must submit pre-treatment and post-treatment radiographs to HRSA.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D3346	Retreatment of previous root canal therapy – anterior	Yes	See Appendix	See Appendix
D3347	Retreatment of previous root canal therapy – bicuspid	Yes	See Appendix	See Appendix
D3348	Retreatment of previous root canal therapy – molar Not covered for wisdom teeth	Yes	See Appendix	See Appendix

Apexification/Recalcification Procedures

Not covered on primary teeth.				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3351	**Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc** Tooth designation required.	No	See Appendix	See Appendix
D3352	**Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** HRSA pays up to 5 medically necessary visits. Tooth designation required.	No	See Appendix	See Appendix

Apexification/Periradicular Services

Not covered on primary teeth				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3410	**Apicoectomy/periradicular surgery – anterior** Tooth designation required.	No	See Appendix	See Appendix
D3421	**Apicoectomy/periradicular surgery – bicuspid (first root)** Tooth designation required.	No	See Appendix	See Appendix
D3425	**Apicoectomy/periradicular surgery – molar (first root)** Tooth designation required.	No	See Appendix	See Appendix
D3426	**Apicoectomy/periradicular surgery (each additional root)** Tooth designation required.	No	See Appendix	See Appendix
D3430	**Retrograde filling, per root** Only covered if done with apicoectomy. Tooth designation required.	No	See Appendix	See Appendix

Other Endodontic Procedures

Anterior primary teeth are not covered				
Procedure Code	**Description/Limitations**	**Prior Auth?**	**Maximum Allowable**	
			0-18 Yrs	**19-20 Yrs**
D3950	**Canal preparation and fitting of preformed dowel or post.** HRSA covers only the dowel or post portion of this procedure. Payable only once per tooth and may include multiple dowels or posts. Tooth designation required.	No	See Appendix	See Appendix

Periodontics

Surgical Services

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant Quadrant designation required.	No	See Appendix	See Appendix

Non-Surgical Periodontal Service

For CDT code D4341:

- Allowed for clients age 19-20 and DDD clients (see page D.5).
- **Not covered for clients age 0-18.**
- Allowed only when the client has radiographic evidence of periodontal disease.
- There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis.
- Allowed only when the client's clinical condition meets existing periodontal guidelines.
- Allowed once per quadrant in 24-month period, quadrant designation is required.
- Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.
- Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4341	Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant	No	See Appendix	See Appendix
D4342	Periodontal scaling and root planing (1-3 teeth, per quadrant)	No	See Appendix	See Appendix

Periodontal Maintenance

- Allowed for DDD clients three times per year;
- Allowed for clients age 19 through 20 every 12 months;
- Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy;
- Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
- Allowed when the client's clinical condition meets existing periodontal guidelines;
- Allowed when periodontal maintenance starts at least 12 months after completion of periodontal scaling and root planing or surgical treatment and paid only at 12-month intervals.
- Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
D4910	**Periodontal Maintenance** [full mouth – not per quadrant]	No	See Appendix	See Appendix

Dentures & Partial Dentures for Children

Use the seating date to bill for dentures.

Initial Set of Dentures

[Refer to WAC 388-535-1080(1)(2)]

- The Health and Recovery Administration (HRSA) covers for children only one maxillary denture and one mandibular denture per client in a ten-year period, **and considers that set to be the first set**.

- **HRSA does not require prior authorization for the first set of dentures.** (See exception for laboratory and professional fees for dentures and partials, page D.36.)

- The first set of dentures may be any of the following:

  - ✓ An immediate set (constructed prior to removal of the teeth);
  - ✓ An initial set (constructed after the client has been without teeth for a period of time); or
  - ✓ A final set (constructed after the client has received immediate or initial dentures).

- The first maxillary denture and the first mandibular denture must be of the structure and quality to be considered the primary set. HRSA does not cover transitional or treatment dentures.

Partials [Refer to WAC 388-535-1080(3)]

- HRSA covers partials (resin and cast base) once every five years subject to the following limits:

  - ✓ Cast base partials only when replacing three or more teeth per arch excluding wisdom teeth; and
  - ✓ No partials are covered when they replace wisdom teeth only.

Exception: The exception to this is replacement dentures, which may be allowed as specified under *Replacement of Complete or Partial Dentures*.

Replacement of Complete or Partial Dentures

[Refer to WAC 388-535-1080(4)]

HRSA requires prior authorization for replacement dentures or partials requested within one year of the seat date.

- HRSA does not require prior authorization for replacement dentures or partials when:

  ✓ The client's existing dentures or partials meet **one of the following conditions**:

  - ➢ No longer serviceable and cannot be relined or rebased; or
  - ➢ Damaged beyond repair; and

  ✓ The client's health would be adversely affected by absence of dentures; and
  ✓ The client has been able to wear dentures successfully; and
  ✓ The need for dentures or partials meet the criteria of medically necessary.

- Dentures replacing a lost maxillary denture and/or a mandibular denture must not exceed HRSA's limit of one set in a ten-year period.

For partial dentures:

✓ Chart the **missing teeth** on the claim form **and** in the client's record; **and**
✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

For complete dentures:

✓ In the "Remarks" field on the ADA claim form, write the justification for replacement of complete or partial dentures; or
✓ If billing electronically, enter the justification in the "Comments/Remarks" field.

Laboratory and Professional Fees for Dentures and Partials

[Refer to WAC 388-535-1080(5)]

- HRSA does not reimburse separately for laboratory and professional fees for dentures and partials. However, HRSA may partially reimburse for these fees when the provider obtains prior authorization and the client:

  - ✓ Dies;
  - ✓ Moves from the state;
  - ✓ Cannot be located; or
  - ✓ Does not participate in completing the dentures.

Rebase **[Refer to WAC 388-535-1080(10)(11)]**

HRSA covers one rebase in a five-year period; the dentures must be at least three years old.

Billing **[Refer to WAC 388-535-1080(7)(8)(9)]**

- For billing purposes, the provider may use the impression date as the service date for dentures, including partials, only when:

  - ✓ Related dental services including laboratory services were provided during a client's eligible period; and
  - ✓ The client is not eligible at the time of delivery.

- For billing purposes, the provider may use the delivery date as the service date when the client is using the first set of dentures in lieu of noncovered transitional or treatment dentures after oral surgery.

- HRSA includes the cost of relines and adjustments that are done within six months of the seat date in the reimbursement for the dentures.

The requirements in this section also apply to overdentures.

Dentures, partial dentures and rebased dentures require labeling in accordance with RCW 18.32.695.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Complete Dentures (including six months post-delivery care)

- The HRSA dental program covers one set of dentures in a ten-year period.
- Dentures placed immediately must be of structure and quality to be considered the permanent set. **Transitional dentures are not covered**.
- No additional reimbursement is allowed for denture insertions.

D5110	Complete denture – maxillary (upper)	No	See Appendix	See Appendix
D5120	Complete lower – mandibular (lower)	No	See Appendix	See Appendix
D5130	Immediate denture – maxillary (upper) Appropriate radiographs must be submitted to HRSA.	No	See Appendix	See Appendix
D5140	Immediate denture – mandibular (lower) Appropriate radiographs must be submitted to HRSA.	No	See Appendix	See Appendix

Partial Dentures (including six months post-delivery care)

- One partial per arch is covered.
- D5211 and D5212 are covered for one or more teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing three or more teeth per arch, excluding wisdom teeth.
- HRSA pays for partials covered by HRSA once in five years.

D5211	**Maxillary partial denture – resin base** (includes any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5212	**Mandibular partial denture – resin base** (including any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5213	**Maxillary partial denture – cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth)	No	See Appendix	See Appendix
D5214	**Mandibular partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth)	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Lab and Professional Fees for Complete/Partial Dentures

D5899	**Unspecified removable prosthodontic procedure** Laboratory and professional fees may be paid for complete dentures or partial dentures if the client: • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. **Requires prior authorization from HRSA.** When requesting prior authorization, you must attach an invoice listing laboratory prescriptions and fees.	Yes	See Appendix	See Appendix

Adjustments to Dentures and Partials

• No allowance for adjustments for 6 months following placement. • Adjustments done during this period are included in denture/partial allowance.				
D5410	**Adjust complete denture – maxillary** (upper)	No	See Appendix	See Appendix
D5411	**Adjust complete denture – mandibular** (lower)	No	See Appendix	See Appendix
D5421	**Adjust partial denture – maxillary** (upper)	No	See Appendix	See Appendix
D5422	**Adjust partial denture – mandibular** (lower)	No	See Appendix	See Appendix

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	See Appendix	See Appendix
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Repairs to Partial Dentures

D5610	**Repair resin denture base** Arch designation required.	No	See Appendix	See Appendix
D5620	**Repair cast framework** Arch designation required	No	See Appendix	See Appendix
D5630	**Repair or replace broken clasp** Arch designation required.	No	See Appendix	See Appendix
D5640	**Replace broken teeth – per tooth** Use for initial tooth. Tooth designation required.	No	See Appendix	See Appendix
D5650	**Add tooth to existing partial denture** Tooth designation required.	No	See Appendix	See Appendix
D5660	**Add clasp to existing partial denture** Tooth designation required.	No	See Appendix	See Appendix

Denture Rebase Procedures

D5710	**Rebase complete maxillary denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	See Appendix	See Appendix
D5711	**Rebase complete mandibular denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	See Appendix	See Appendix
D5720	**Rebase maxillary partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	See Appendix	See Appendix
D5721	**Rebase mandibular partial denture** Requires justification (e.g., lost vertical dimension, incorrect bite). Original dentures must be at least 3 years old. Rebase allowed once in a 5-year period.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Denture Relining

• Relines are included in allowance for dentures if service is provided within first six months of placement of dentures. • Reline of partial or full dentures is not allowed more than once in a 5-year period.				
D5750	**Reline complete maxillary denture (laboratory)**	No	See Appendix	See Appendix
D5751	**Reline complete mandibular denture (laboratory)**	No	See Appendix	See Appendix
D5760	**Reline maxillary partial denture (laboratory)**	No	See Appendix	See Appendix
D5761	**Reline mandibular partial denture (laboratory)**	No	See Appendix	See Appendix

Other Removable Prosthetic Services

D5850	**Tissue conditioning, maxillary** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	See Appendix	See Appendix
D5851	**Tissue conditioning, mandibular** Included in allowance for dentures if service is provided within first six months of placement of dentures.	No	See Appendix	See Appendix
D5860	**Overdenture – Complete** Arch designation required.	No	See Appendix	See Appendix
D5932	**Obturator prosthesis, definitive**	No	See Appendix	See Appendix
D5933	**Obturator prosthesis, modification**	No	See Appendix	See Appendix
D5952	**Speech aid prosthesis, pediatric** Covered for clients age 19 and 20 for cleft palate.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Prosthodontics, Fixed Repairs

Prosthodontics, Fixed Repairs

D6930	**Recement fixed partial denture (bridge)**	No	See Appendix	See Appendix

Management of Temporomandibular Joint Dysfunction

D7880	**Occlusal orthotic device** **[Allowed for TMJ/TMD or bruxism only.]** Laboratory-processed only. Requires prior authorization. Justification must include diagnosis. Laboratory invoice must be kept in the client's file. The maximum allowance includes all professional fees, lab costs, and all required follow-ups. One appliance allowed in a two-year period. **Use the seat date to bill for occlusal orthotic device.**	**Yes**	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Oral Surgery – Dentists

HRSA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

- The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
- Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page D.10); and
- A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7111	**Coronal remnants deciduous t**	No	See Appendix	See Appendix
D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	See Appendix	See Appendix

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Surgical removal of anterior teeth (7-10 and 23-26) requires prior authorization and must be justified with radiographs. Tooth designation required.	**See Desc.**	See Appendix	See Appendix
D7220	**Removal of impacted tooth – soft tissue** Tooth designation required.	No	See Appendix	See Appendix
D7230	**Removal of impacted tooth – partially bony** Tooth designation required.	No	See Appendix	See Appendix
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation required.	No	See Appendix	See Appendix
D7241	**Removal of impacted tooth - completely bony**, with unusual surgical complications Allowed only when pathology is present. Tooth designation required.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Surgical Extractions (Continued)

D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation required.	No	See Appendix	See Appendix
HRSA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]				

Other Surgical Procedures

D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus Permanent teeth only. Tooth designation required.	No	See Appendix	See Appendix
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons. Includes orthodontic attachments. Tooth designation required; limited to clients age 20 and younger.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Adjunctive General Services

Unclassified Treatment

D9110	**Palliative (emergency) treatment of dental pain – minor procedure** Emergency palliative treatment is: • Allowed only when no other definitive treatment is performed on the same day; and • Allowed once per client, per day. Separate charges are allowable for open and drain and for root canal treatment if the procedures are performed on different days. A description of the service must be documented in the client's file.	No	See Appendix	See Appendix

Anesthesia

- HRSA covers general anesthesia, conscious sedation, and parenteral or multiple oral agents for medically necessary dental services as follows:

  - ✓ For treatment of clients of the Division of Developmental Disabilities;
  - ✓ For oral surgery procedures;
  - ✓ When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record.
  - ✓ When the anesthesia is administered by:

    - ➢ An oral surgeon
    - ➢ An anesthesiologist;
    - ➢ A dental anesthesiologist;
    - ➢ A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH);
    - ➢ A dentist who has a conscious sedation permit (for conscious sedation with parenteral or multiple oral agents) issued by DOH that is current at the time the billed service(s) is provided; or
    - ➢ A dentist who has a general anesthesia permit (for deep sedation or general anesthesia) issued by DOH that is current at the time the billed service(s) is provided.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When general anesthesia (including deep sedation) is administered by:

  - ✓ The attending dentist, HRSA reimburses at the rate of 50% of the maximum allowable rate.
  - ✓ A provider other than the attending dentist, HRSA reimburses at the maximum allowable rate.

- When billing for general anesthesia, show the beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs
• HRSA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist: **$102.20 + [TIME UNITS X $20.44] = MAXIMUM ALLOWABLE FEE** **Note: Every 15 minute increment or fraction equals 1 time unit.**				
• Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to HRSA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*).				
D9220	**Deep sedation/general anesthesia** When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record. HRSA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(A General Anesthesia permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix	See Appendix
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide** HRSA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	See Appendix	See Appendix
D9241	**Intravenous conscious sedation/analgesia** Conscious sedation with parenteral agents. **(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix	See Appendix
D9248	**Non-intravenous conscious sedation** Conscious sedation with multiple oral agents. **(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.
- Mass screening for dental services of clients residing in a facility is not permitted.

D9410	**House/extended care facility call** Allowed once per day (not per client and not per facility), per provider.	No	See Appendix	See Appendix
D9420	**Hospital calls (includes emergency care)** Allowed once per day, per client, per provider. Not covered for routine preoperative and postoperative visits.	No	See Appendix	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable	
			0-18 Yrs	19-20 Yrs

Drugs

D9610	**Therapeutic drug injection.** Antibiotics only. Includes cost of drug.	No	See Appendix	See Appendix
D9630	**Other drugs and/or medicaments** Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. HRSA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	See Appendix	See Appendix

Miscellaneous Services

D9920	**Behavior management** Involves a client whose documented behavior requires the assistance of **one additional dental professional staff** to protect the patient from self-injury while treatment is rendered.	No	See Appendix	See Appendix
D9951	**Occlusal adjustment, limited** • Allowed once every 12 months – per quadrant; • Quadrant designation required; and • Is included in the fee for restorations or crowns placed by the same provider.	No	See Appendix	See Appendix

Coverage Adults

When does MAA pay for covered dental-related services for adults? [Refer to WAC 388-535-1255(1)]

MAA pays for covered dental and dental-related services listed in this section **only** when they are:

a) Within the scope of the eligible client's medical care program;
b) Medically necessary; and
c) Within accepted dental or medical practice standards and are:

   i. Consistent with a diagnosis of dental disease or condition; and
   ii. Reasonable in amount and duration of care, treatment, or service.

Items and services are subject to the specific limitations listed in the fee schedule, see Fee Schedule beginning on page E.18.

What dental services are covered for adults?

[Refer to WAC 388-535-1255(2)]

MAA covers the following dental-related services for eligible adults, subject to the restrictions and limitations in this section and other applicable WAC:

a) Medically necessary services for the identification of dental problems or the prevention of dental disease.

b) A **comprehensive oral evaluation** once per provider as an initial examination that must include:

   i. A complete dental and medical history and a general health assessment;
   ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and
   iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.

   Note: MAA does **not** pay separately for chart or record set-up. The fees for these services are included in MAA's reimbursement for Comprehensive Oral Evaluations.

c) **Periodic oral evaluation** once every six months to include a periodontal screening/charting at least once per year. There must be six months between the comprehensive oral evaluation and the first periodic oral evaluation.

Note: MAA does **not** pay separately for chart or record set-up. The fees for these services are included in MAA's reimbursement for Comprehensive Oral Evaluations.

d) **Limited oral evaluations** only when the provider is not providing pre-scheduled dental services for the client. The limited oral evaluation must be:

i. To provide limited or emergent services for a specific dental problem; and/or
ii. To provide an evaluation for a referral.

Note: MAA does **not** pay separately for chart or record set-up. The fees for these services are included in MAA's reimbursement for Comprehensive Oral Evaluations.

e) **Radiographs**, as follows:

i. Intraoral, complete series (including bitewings), allowed only once in a three-year period;
ii. Panoramic film, allowed only once in a three-year period and only for oral surgical purposes;
iii. Periapical radiographs as needed (periapical radiographs and bitewings taken on the same date of service cannot exceed MAA's fee for a complete intraoral series); and
iv. Bitewings, up to four allowed every 12 months.

f) **Fluoride treatment** as follows:

i. Topical application of fluoride gel or fluoride varnish for adults age 19 through 64 with xerostomia (requires prior authorization); and
ii. Topical application of fluoride gel or varnish for adults age 65 and older for:

A. Rampant root surface decay; or
B. Xerostomia.

g) **Oral prophylaxis treatment,** which is:

i. Allowed once every 12 months for adults age 19 and older, including nursing facility clients.
ii. Allowed for clients of the Division of Developmental Disabilities (see page E.6 for specifics);
iii. Not reimbursed when oral prophylaxis treatment is performed on the same date of service as periodontal scaling and root planing, gingivectomy, or gingivoplasty;
iv. Reimbursed only if periodontal maintenance is not billed for the same client within the same 12-month period.

h) **Restoration of teeth and maintenance of dental health**, subject to the limitation in WAC 388-535-1260 and as follows:

i. Amalgam and composite restorations are allowed once in a two-year period for the same surface of the same tooth per client, per provider;

ii. Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multisurface restoration. Payment is limited to that of a multisurface restoration.

For example:

- MO restoration and a DO restoration on the same tooth must be billed as an MOD, except for teeth 2, 3, 14, and 15.
- MOB restoration and a DO restoration on the same tooth must be billed as an MODB, except for teeth 2, 3, 14, and 15.
- MOL restoration and a DO restoration on the same tooth must be billed as an MODL, except for teeth 2, 3, 14, and 15.
- Buccal and Lingual grooves must not be billed separately.

iii. Proximal restorations that do not involve the incisal angle in the anterior teeth are considered to be a two-surface restoration. Payment is limited to a two-surface restoration.

iv. Proximal restoration that involve the incisal angle are considered to be either a three- or four-surface restoration. All surfaces must be listed on the claim for payment.

v. MAA pays for a maximum of six surfaces for a posterior tooth, which is allowed once per client, per provider, in a two-year period.

vi. MAA pays for a maximum of six surfaces for an anterior tooth, which is allowed once per client, per provider, in a two-year period.

vii. MAA pays for a core buildup on an anterior or a posterior tooth, including any pins, which is allowed once per client, per provider, in a two-year period, subject to the following:

- MAA does not pay for a core buildup when a permanent or temporary crown is being placed on the same tooth.
- MAA does not pay for a core buildup when placed in combination with any other restoration on the same tooth on the same date of service.

viii. MAA pays for flowable composites as a restoration only when used with a cavity preparation for a carious lesion that penetrates through the enamel:

- As a small Class I (occlusal) restoration; or
- As a Class V (buccal or lingual) restoration.

i) **Root canal therapy for permanent anterior teeth only.**

j) **Periodontal scaling and root planing**, which is:

i. Allowed for clients of the Division of Developmental Disabilities (see page E.6);
ii. Allowed for clients age 19 and older;
iii. Allowed only when the client has radiographic evidence of periodontic disease. There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis;
iv. Allowed once per quadrant in a 24-month period;
v. Allowed only when the client's clinical condition meets existing periodontal guidelines; and
vi. Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.

k) **Periodontal maintenance**, which is:
   i. Allowed for DDD clients (see page E.6);
   ii. Allowed every six months for clients age 21 and older;
   iii. Allowed only when the client has been previously treated for periodontal disease, including surgical or non-surgical periodontal therapy;
   iv. Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
   v. Allowed when the client's clinical condition meets existing periodontal guidelines;
   vi. Allowed when periodontal maintenance starts at least six months after completion of periodontal scaling and root planing or surgical treatment and paid only at six-month intervals; and
   vii. Not reimbursed when the periodontal maintenance is performed on the same date of service as periodontal scaling and root planing, gingivectomy, or gingivoplasty.
   viii. Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

l) **Dentures and partial dentures** (see page E.28 for limitations);

m) **Simple extractions** (includes local anesthesia, suturing and routine postoperative care);

n) **Surgical extractions**, subject to the following:

   i. Includes local anesthesia, suturing, and routine postoperative care; and
   ii. Requires documentation and radiographs in the client's file to support soft tissue, partially bony, or completely bony extractions.

> **Excludes teeth 7, 8, 9, 10, 23, 24, 25, and 26** which are considered simple extractions and must be billed as such. To request MAA's consideration for surgical reimbursement for these teeth, submit your request using the Prior Authorization process listed on page E.13. In an emergency the Prior Authorization may be done after the extraction

o) **Medically necessary oral surgery** when coordinated with the client's managed care plan (if any);

p) **Palliative (emergency) treatment** of dental pain and infections, minor procedures, which is

   i. Allowed once per client, per day.
   ii. Reimbursed only when performed on a different date from:
      A. Any other definitive treatment necessary to diagnose the emergency condition; and
      B. Root canal therapy.
   iii. Reimbursed only when a description of the service provided is included in the client's record.

What additional dental services are covered for DDD clients? [Refer to WAC 388-535-1255(3)]

For clients of the Division of Developmental Disabilities, MAA allows additional services as follows:

a) One of the following teeth cleaning services or combination of teeth cleaning services, subject to the limitations listed:

   i. Prophylaxis or periodontal maintenance, three times per calendar year;
   ii. Periodontal scaling and root planning, two times per calendar year;
   iii. Prophylaxis or periodontal maintenance, two times per calendar year, and periodontal scaling and root planning, two times per calendar year.

b) Gingivectomy or gingivoplasty;
c) Nitrous oxide; and
d) Behavior management that requires the assistance of one additional dental professional staff.

What dental services are covered when provided in a non-office setting? [Refer to WAC 388-535-1255(4) and 388-535-1270(4)]

Providers who bill using CDT codes for the services below must obtain Prior Authorization from MAA. See page E.12.

MAA covers dental services that are medically necessary and provided in a non-office setting (e.g., short stay, ambulatory surgery centers) under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page E.10; and
c) A hospital call, including emergency care, allowed one per day, per client, per provider.

What dental services are covered when provided in a hospital?

Nonemergent oral surgeries performed in an inpatient setting are noncovered. Exceptions to this policy are evaluated for DDD clients whose surgery cannot be performed in an office setting or for medically necessary reconstructive surgery. Exceptions require prior written authorization for the inpatient hospitalization.

When is IV conscious sedation and general anesthesia covered under MAA's Dental Program?

[Refer to WAC 388-535-1255(5) and (6)]

MAA covers general anesthesia and IV conscious sedation with parenteral or multiple oral agents for medically necessary dental services as specified in the Adult Dental Fee Schedule, see page E.17.

What dental-related services are covered for clients residing in nursing facilities or group homes? [Refer to WAC 388-535-1255(7)]

MAA covers dental-related services for clients residing in nursing facilities or group homes as follows:

a) Dental services must be requested by the client or the client's surrogate decision maker (as defined in WAC 388-97-055), or a referral for services must be made by the:

- Attending physician;
- Director of nursing; or
- Nursing facility supervisor.

b) Nursing facilities must provide dental-related necessary services per WAC 388-97-012 (Nursing facility care); and

c) A bedside call at a nursing facility or group home is allowed once per day, per provider (regardless of the number of clients seen).

What are the coverage limits for dental-related services provided under state-only funded programs?

[Refer to WAC 388-535-1065]

MAA covers the dental services described and limited in this billing instruction and under chapter 388-535 WAC for clients eligible for GA-U or GA only when those services are provided as part of a medical treatment for:

- Apical abscess verified by clinical examination with radiographs, and treated by:

  - ✓ Open and drain palliative treatment;
  - ✓ Tooth extraction; or
  - ✓ Root canal therapy for permanent anterior teeth only.

- Tooth fractures (limited to extraction);

- Total dental extraction performed prior to and because of radiation therapy for cancer of the mouth.

See next page for list of procedure codes covered under this program.

GA-U/GA Covered Procedure Codes:

CDT	11640	13152	21385	41007
D0140	11641	13153	21406	41008
D0220	11642	13160	21421	41009
D0230	11643	14040	21422	41010
D0330	11644	20220	21423	41015
D3310	11646	20520	21431	41016
D7111	12001	21030	21432	41017
D7140	12002	21034	21433	41018
D7210	12004	21040	21435	41100
D7220	12005	21041	21436	41105
D7230	12011	21044	21445	41108
D7240	12013	21045	21452	41110
D7241	12014	21046	21453	41112
D7250	12015	21047	21454	41113
D9110	12016	21141	21461	41114
D9220	12031	21142	21462	41825
D9420	12032	21143	21470	41826
D9630	12034	21336	30580	41827
	12035	21337	40800	42100
	12051	21344	40801	42104
CPT	12052	21345	40804	42106
11100	12053	21346	40805	42180
11101	12054	21347	40808	42182
11440	12055	21348	40810	42235
11441	13131	21355	40812	
11442	13132	21356	40814	
11443	13133	21360	41000	
11444	13150	21365	41005	
11446	13151	21366	41006	

See page E.17 – Dental Fee Schedule for Maximum Allowable Fees, Limitations, and Additional Required Documentation

What dental services are not covered for adults?

[Refer to WAC 388-535-1265(1) and (2)]

MAA does not cover the following dental services unless the services are:

- Included in a MAA-waivered program; or
- Part of one of the Medicare programs for Qualified Medicare Beneficiaries (QMB), except for QMB-only, which is not covered.

MAA does **not cover** the following dental-related services for adults:

a) **Any services specifically excluded by statute**.

b) **More costly services** when less costly, equally effective services as determined by the department are available;

c) Services, **procedures**, treatments, devices, drugs, or application of associated services which the department of the Centers for Medicare and Medicaid Services (CMS) consider **investigative or experimental** on the date the services were provided;

d) Coronal polishing;

e) **Fluoride treatments (gel or varnish) for adults**, unless the clients are:

   i. Clients of the Division of Developmental Disabilities;
   ii. Diagnosed with xerostomia, age 19-64, in which case the provider must request **prior authorization**; or
   iii. High-risk adults, 65 years of age and older. High-risk means the client has at least one of the following:

      A. Rampant root surface decay; or
      B. Xerostomia.

f) **Restorations** for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface**.**

g) Flowable composites for interproximal or incisal restorations;

h) Nitrous oxide, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

i) Behavior management, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

j) Occlusal adjustments;

k) Any **permanent crowns, temporary crowns,** or crown post and cores.

l) **Bridges**, including abutment teeth and pontics.

m) **Root canals** for **primary teeth**.

n) **Root canals** for **permanent teeth** other than teeth 6, 7, 8, 9, 10, 11, 22, 23, 25, 26, and 27.

o) **Pulpotomy** for permanent teeth.

p) **Transitional dentures**.

q) **Overdentures**.

r) **Replacements** for:

i. Immediate maxillary or mandibular dentures;
ii. Maxillary or mandibular partial dentures (resin); or
iii. Complete maxillary or mandibular dentures in excess of one replacement in a ten-year period; or
iv. Cast metal framework maxillary or mandibular partial dentures in excess of one replacement in a ten-year period.

s) **Rebasing** of complete dentures and partial dentures.

t) **Adjustments** of complete dentures and partial dentures.

t) **Tooth implants**, including insertion, post-insertion, maintenance, and implant removal.

u) **Periodontal bone grafts** or oral soft tissue grafts.

v) **Gingivectomy or gingivoplasty** (except for DDD clients – see page E.6).

w) **Frenectomy or frenoplasty**, and other periodontal surgical procedures.

x) **Crown lengthening** procedures.

y) **Orthotic appliances**, including but not limited to, night guards, temporomandibular joint dysfunction (TMJ/TMD) appliances, and all other mouth guards.

z) **Any treatment of TMJ/TMD**.

aa) **Extraction** of asymptomatic teeth (including wisdom teeth).

bb) **Alveoloplasty, alveoloectomy tori, or exostosis removal**.

cc) **Debridement of granuloma or cysts associated with tooth extraction**.

dd) **Cosmetic treatment or surgery**, except as prior authorized by the department for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defects, or illness.

ee) **Nonemergent oral surgery** for adults performed in an inpatient hospital setting, **except**:

i. Nonemergent oral surgery is covered in an inpatient hospital setting for clients of the Division of Developmental Disabilities when written prior authorization is obtained for the inpatient hospitalization; or
ii. As provided under "What dental services are covered when provided in a non-office setting," see page E.6.

ff) Dental supplies such as toothbrushes (manual, automatic, or electric), toothpaste, floss, or whiteners.

gg) Dentist's time writing and calling in prescriptions or prescription refills.

hh) Educational supplies.

ii) Missed or cancelled appointments.

jj) Nonmedical equipment, supplies, personal or comfort items or services.

kk) Provider mileage or travel costs.

ll) Service charges or delinquent payment fees.

mm) Supplies used in conjunction with an office visit.

nn) Take-home drugs.

oo) Teeth whitening.

Authorization

Prior Authorization and expedited prior authorization numbers do not override the client's eligibility or program limitations. Not all categories of eligibility receive all services.

When do I need to get prior authorization?

Authorization must take place before the service is provided.

Authorization is based on the establishment of medical necessity as determined by MAA. When prior authorization is required for a service, MAA considers these requests on a case-by-case basis.

When MAA authorizes a dental-related service for adults, the authorization indicates only that the specific service is medically necessary; it is not a guarantee of payment. MAA may require second opinions and/or consultations before authorizing any procedure. Authorization is valid only if the client is eligible for covered services on the date of service. [WAC 388-535-1270]

In an acute emergency, the department *may* authorize the service after it is provided when the department receives justification of medical necessity. This justification must be received by MAA within three business days of the emergency service.

MAA authorizes requested services that meet the criteria in the "What dental services are covered for adults" section, page E.1.

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When does MAA deny requests for prior authorization?

[Refer to WAC 388-535-1280(3)]

MAA denies a request for dental services when the requested service is:

a) Not listed as a covered service for adults on pages E.1–E.5;
b) Not medically necessary;
c) A service, procedure, treatment, device, drug, or application of associated service that the department or the Centers for Medicare and Medicaid Services (CMS) consider investigative or experimental on the date the service is provided; or
d) Covered under another DSHS program or by an agency outside DSHS.

Which services require prior authorization?

[Refer to WAC 388-535-1270]

The following dental-related services for adults require prior authorization:

1) Nonemergent inpatient hospital dental admissions;
2) Short stays and services provided in an ambulatory surgery centers;
3) Dentures and partial dentures (see page E.28);
4) Fluoride treatment (gel or varnish) for clients age 19 through 64 who are diagnosed with xerostomia; and
5) Selected procedures identified by MAA (see Fee Schedule for adults).

The Dental Fee Schedule indicates which services require prior authorization. In the Prior Authorization column:

No	=	Prior Authorization for these services is not required. However, the service must be provided in accordance with the policies indicated for each procedure.
Yes	=	Prior Authorization is required for these services.

How do I obtain written prior authorization?

[Refer to WAC 388-535-1280(1)]

MAA requires a dental provider who is requesting prior authorization to submit sufficient, objective, clinical information to establish medical necessity.

The request must be submitted in writing on a completed ADA Claim Form and include the following:

- The client's name and date of birth;
- The client's patient identification code (PIC);
- The provider's name and address;
- The provider's telephone number (including area code); and
- The provider's assigned 7-digit MAA provider number.

Also…

- The physiological description of the disease, injury, impairment, or other ailment;
- The most recent and relevant radiographs that are identified with client name, provider name, and date the radiographs were taken. *Radiographs should be duplicates as originals are to be maintained in the client's chart.*
- The proposed treatment;
- Periodontal charting (when radiographs do not sufficiently support the medical necessity for the extractions);
- Study model (if requested); and
- Photographs (if requested).

(Refer to Section H, How to Complete the ADA Claim Form.)

If MAA approves your request, the ADA Dental Claim Form will be returned to you with an authorization number. **This original form** is to be completed and submitted for payment. Keep a copy for your records.

Where should I send requests for prior authorization?

Mail your request, along with required radiographs, to:

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs
Fax: (360) 725-2123 On-line update 9/16/04

☞ **Note**: Include return fax number on all faxed requests for prior authorizations.

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Dental services that are listed as **"Requires Expedited Prior Authorization"** in the fee schedule must have the assigned EPA number for that procedure on the ADA Claim Form when billing. By placing the appropriate EPA number on the ADA Claim Form when billing MAA, dental providers are verifying that the EPA criteria for that procedure code have been met.

Once the EPA criteria are met, use the 9-digit EPA number listed next to the procedure code in the fee schedule.

☞ **Note:** Dental providers are reminded that these unique EPA numbers are ONLY for the procedure codes listed in the fee schedule as "Requires Prior Authorization."

Exceeding Limitations or Restrictions
A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. MAA may evaluate and approve requests for LE for dental-related services when medically necessary, as determined by MAA, under the provisions of WAC 388-501-0165. **[WAC 388-535-1080(7)]**

Dental Fee Schedule

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT)
Column 2: Description/Limitations
Column 3: Prior Auth? Is prior authorization required?
Column 4: Maximum Allowable – Adults age 21 and older.

Always bill your usual and customary fee(s) (not HRSA's maximum allowable amount).

Remember: You may bill only after services have been provided, but HRSA must receive your bill within 365 days from the date of service.

Unless otherwise specified, HRSA uses the descriptions of the ADA codes as listed in the CDT manual.

Diagnostic

Clinical Oral Evaluations

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
HRSA does **not** pay separately for chart or record set-up. The fees for these services are included in HRSA's reimbursement for Comprehensive Oral Evaluations (D0150) and Limited Oral Evaluations (D0140).			
D0120	**Periodic oral evaluation** A periodic evaluation is allowed once every six months. A comprehensive examination must precede a periodic oral evaluation by at least six months.	No	See Appendix
D0140	**Limited oral evaluation** An evaluation limited to a specific oral health problem. A limited examination may also be billed when providing an evaluation for a referral. May not be billed when any prescheduled dental service is provided on the same date – except for palliative treatment and radiographs, necessary to diagnose the emergency condition.	No	See Appendix
D0150	Comprehensive oral evaluation **An initial evaluation is allowed once per** **client, per provider or clinic, and must** **include:** i. A complete dental and medical history and a general health assessment; ii. A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; and iii. The evaluation and recording of dental caries, missing or erupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening.	No	See Appendix

Procedure Code	EPA Number	Description & Expedited Prior Authorization Criteria	Maximum Allowable 21 yrs & up

Limited Visual Oral Assessment

THIS PROCEDURE CODE REQUIRES EXPEDITED PRIOR AUTHORIZATION.
See page E.16 for information on the Expedited Prior Authorization process.

A limited visual oral health assessment does not replace an oral evaluation by a dentist.

D9999	870000998	Limited visual oral assessment **EPA Criteria** When billing for this code (D9999) and placing the assigned EPA number onto the ADA claim form, a dental provider is verifying that one of the following occurred: • Triage services were provided; • A public health dental hygienist performed an intraoral screening of soft tissues to assess the need for prophylaxis, fluoride, or referral for other dental treatments by a dentist; or • In circumstances where the client will be referred to a dentist for treatment, the referring provider will not provide treatment or provide a full evaluation at the time of the assessment. This procedure also includes appropriate referrals, charting, patient data and oral health status, and informing the parent or guardian of the results.	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Radiographs

Doing <u>both</u> a panoramic film and an intraoral complete series is not allowed.

Limitations:

- Periapical radiographs and bitewings on the same date of service cannot exceed HRSA's maximum allowable for a complete series.
- A maximum of four bitewing radiographs will be paid in a 12-month period.
- When billing D0270 and D0272 on the same date of service, HRSA's total reimbursement amount will not exceed the reimbursement for D0274.

D0210	**Intraoral – complete series** (including bitewings) A complete intraoral series consists of 14 periapicals and one series of 4 bitewings. Complete series radiographs will be allowed only once in a 3-year period.	No	See Appendix
D0220	**Intraoral periapical – single, first film**	No	See Appendix
D0230	**Intraoral periapical – each additional film**	No	See Appendix
D0270	**Bitewing – single film** Total of 4 bitewings allowed every 12 months.	No	See Appendix
D0272	**Bitewings – 2 films** Total of 4 bitewings allowed every 12 months	No	See Appendix
D0274	**Bitewings – 4 films** Total of 4 bitewings allowed every 12 months.	No	See Appendix
D0330	**Panoramic film – Maxilla and mandilla** Allowed once in a three-year period for oral surgical purposes or for DDD clients. • Not to be used for restoration diagnostic purposes. • A panoramic radiograph and an intraoral complete series cannot be billed within the same 3-year period. • A shorter interval between panoramic radiographs may be allowed for: ✓ Emergent services, with authorization from HRSA within three working days of the service; ✓ Oral surgery, with written prior authorization from HRSA; or ✓ Preoperative or postoperative surgery cases. Preoperative radiographs must be provided within 14 days prior to surgery, and postoperative radiographs must be provided within 30 days after surgery.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Preventive

Prophylaxis

D1110	**Prophylaxis – Adult** • Allowed once every 12 months. • DDD clients may have three prophylaxis every 12 months. • Not allowed when performed on the same date of service as periodontal scaling and root planing, gingivectomy or gingivoplasty. • Reimbursed only if periodontal maintenance is not billed for the same client within the same 12-month period.	No	See Appendix

Fluoride Treatments

Document in the client's file which material (e.g., topical gel or fluoride varnish) is used.			
D1204	**Topical application of fluoride [gel or varnish]** Allowed up to three times in a 12-month period for: • DDD clients; • Adults age 19 through 64 with xerostomia - **prior authorization required**; or • High-risk adults age 65 and older with: ✓ Rampant root surface decay; or ✓ Xerostomia.	Yes	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Restorative

Amalgam Restorations (including polishing)

- Amalgam restorations are covered once in a two-year period for the same surface of the same tooth per client, per provider, subject to the following:
  - ✓ Replacement of restorations is not allowed within a two-year period, unless the restoration has an additional adjoining carious surface, then all restored surfaces will be covered.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multi-surface restoration. Payment is limited to that of a single multi-surface restoration, except for teeth 2, 3, 14 and 15 (see page E.4).
- A maximum of six surfaces for a posterior tooth are allowed once per client, per provider, in a two-year period.
- Bases and polishing amalgams are included in the allowance for the major restoration.

D2140	**Amalgam – 1 surface, primary or permanent** Tooth and surface designations required.	No	See Appendix
D2150	**Amalgam – 2 surfaces, primary or permanent** Tooth and surface designations required**.**	No	See Appendix
D2160	**Amalgam – 3 surfaces, primary or permanent** Tooth and surface designations required.	No	See Appendix
D2161	**Amalgam – 4 or more surfaces, primary or permanent** Tooth and surface designations required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Resin-Based Composite Restorations (Composite/Glass Ionomer)

- Composite restorations are covered once in a two-year period for the same surface of the same tooth, per client, per provider subject to the following:
  - ✓ Replacement of restorations is not allowed within a two-year period, unless the restoration has an additional adjoining carious surface, then all restored surfaces will be covered.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multi-surface restoration, except for teeth 2, 3, 14, and 15. Payment is limited to that of a single multi-surface restoration.
- Any interproximal restoration that does not involve the incisal angle in the anterior teeth is considered to be a **two-surface** restoration.
- Interproximal restorations involving the incisal angle are considered to be either a three or four surface restoration. All surfaces must be listed for payment.
- Buccal or lingual class V restorations may be billed as a separate single surface restoration.
- A maximum of six surfaces for an anterior or posterior tooth are allowed once per client, per provider, in a two-year period.
- HRSA covers flowable composites as a restoration only when used with a cavity preparation for a carious lesion that penetrates the enamel (see page E.3).
- HRSA does not cover flowable composites for interproximal or incisal restorations.

D2330	**Resin-based composite – 1 surface, anterior** Tooth and surface designations required.	No	See Appendix
D2391	**Resin-based composite – 1 surface, posterior** Tooth and surface designations required.	No	See Appendix
D2392	**Resin-based composite – 2 surfaces, posterior** Tooth and surface designations required.	No	See Appendix
D2393	**Resin-based composite – 3 surfaces, posterior** Tooth and surface designations required.	No	See Appendix
D2394	**Resin-based composite, 4 or more surfaces, posterior** Tooth and surface designations required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Other Restorative Services

D2950	**Core build-up (including any pins)** HRSA pays for a core buildup on an anterior or a posterior tooth, including any pins, which is allowed once per client, per provider, in a two-year period, subject to the following: • HRSA does not pay for a core buildup when placed in combination with any other restoration on the same tooth on the same date of service. • Tooth designation required.	No	See Appendix

Endodontic

Root Canal Therapy

D3310	**Anterior (excluding final restorations)** • Includes pre-treatment diagnostic tests; • Includes follow-up treatment; and • Not covered for primary teeth. • Tooth designation required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Periodontics

Surgical Services

D4210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant** Quadrant designation required. Allowed once every three years	No	See Appendix

Periodontal Scaling and Root Planing

- Allowed for DDD clients (see page E.6).
- Allowed for clients age 19 and older.
- Allowed only when the client has radiographic evidence of periodontal disease.
- There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis.
- Allowed only when the client's clinical condition meets existing periodontal guidelines.
- Allowed once per quadrant in 24-month period, quadrant designation is required.
- Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.
- Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing.

D4341	**Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant**	No	See Appendix
D4342	**Periodontal scaling and root planing (1-3 teeth, per quadrant)**	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Periodontal Maintenance

- Allowed for DDD clients three times per year;
- Allowed for clients age 19 and older every 6 months;
- Allowed only when the client has been previously treated for periodontal disease, including surgical or nonsurgical periodontal therapy;
- Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
- Allowed when the client's clinical condition meets existing periodontal guidelines;
- Allowed when periodontal maintenance starts at least 6 months after completion of periodontal scaling and root planing or surgical treatment and paid only at 6-month intervals.
- Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

D4910	**Periodontal Maintenance** [full mouth – not per quadrant]	No	See Appendix

Dentures/Partial Dentures

ALL Dentures, Partial Dentures, and Replacement of Dentures or Partial Dentures REQUIRE PRIOR AUTHORIZATION
See page E.13 for details on requesting prior authorization.

Dentures, partial dentures require labeling in accordance with RCW 18.32.695.

Dentures

[Refer to WAC 388-535-1290(2) and (3)]

HRSA covers the following for eligible adults:

- Only one complete maxillary and one complete mandibular denture per client in a ten-year period, when constructed after the client had been without teeth for a period of time; or

- Only one immediate maxillary denture and one immediate mandibular denture allowed per client, per lifetime, and only when constructed prior to the removal of the client's teeth.

The dentures must be of an acceptable structure and quality to meet the standard of care. HRSA does not cover transitional dentures.

Partial Dentures

[Refer to WAC 388-535-1290(2)(c)]

HRSA covers the following for eligible adults:

- Only one maxillary partial denture (resin) and one mandibular partial denture (resin) to replace one, two, or three missing anterior teeth per arch, allowed per client in a ten-year period; or

- Only one maxillary partial denture (cast metal framework) and one mandibular partial denture (cast metal framework) allowed per client in a ten-year period to replace:

    a. Any combination of at least six anterior and posterior missing teeth per arch excluding wisdom teeth; or
    b. At least four anterior missing teeth per arch.

Prior Authorization for Complete Dentures

[Refer to WAC 388-535-1290(1)]

- HRSA requires prior authorization for complete dentures.
- Requests for prior authorization must include:

  - ✓ Whether the client was successfully able to wear dentures in the past; and
  - ✓ If not, reason why not and why client would be able to wear dentures now.

Prior Authorization for Immediate Dentures and Partial Dentures [Refer to WAC 388-535-1290(1)]

Clinical justification is required from a dentist for immediate dentures and partial dentures.

- HRSA requires prior authorization for immediate dentures and partial dentures, described in this section.

- For immediate dentures, the client's dentist must initiate request for authorization from HRSA and provide periodontal charting (when appropriate), periodontal diagnosis, and radiographs.

- For partial dentures, the client's dentist must initiate request for authorization from HRSA and provide:

  - ✓ Charting of missing teeth;
  - ✓ Periodontal charting;
  - ✓ Periodontal diagnosis;
  - ✓ Radiographs;
  - ✓ Documentation of whether the client has current partials; and
  - ✓ Documentation of why the partial denture cannot be relined or repaired.

- If a different dentist/denturist is providing the immediate or partial dentures, that dentist/denturist must contact HRSA for the prior authorization number.

Relines **[WAC 388-535-1290(9)(10)]**

- **HRSA covers complete denture and partial denture relines only once in a five-year period.**
- **HRSA does not require prior authorization for repairs.**
- **HRSA does not pay separately for relines that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.**

Repairs [WAC 388-535-1290(5)]

- **HRSA covers complete denture and partial denture repairs, when medically necessary.**
- **HRSA does not require prior authorization for repairs.**
- **HRSA does not pay separately for repairs that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.**

Replacement of Complete Dentures or Partial Dentures

[Refer to WAC 388-535-1290(2)(d) and (6)]

HRSA covers the following for eligible adults:

- Only one replacement of a complete maxillary denture and one replacement of a complete mandibular denture allowed per client in a ten-year period; or

- Only one replacement of a maxillary partial denture (cast metal framework) and a mandibular partial denture (cast metal framework) allowed per client in a ten-year period.

Replacement of complete dentures and partial dentures must:

- Replace a complete maxillary denture, a complete mandibular denture, a maxillary partial denture (cast metal framework) or a mandibular partial denture (cast metal framework);
- Replace dentures or partial dentures that are no longer serviceable and are unable to be relined;
- Replace dentures or partial dentures that are damaged beyond repair; and
- Replace dentures or partial dentures that a client has been able to wear successfully.

Billing [WAC 388-535-1290(7) and (8)]

For billing purposes, the provider must:

a. Use the delivery date as the service date for the dentures and partial dentures; or
b. Use the impression date as the service date for dentures and partial dentures only when:

   i. Related dental services, including laboratory services, were provided during a client's eligible period;
   ii. The client is not eligible at the time of delivery; or
   iii. The client does not return to obtain the dentures or partial dentures.

The provider must document in the client's record:

a. Written laboratory prescriptions;
b. Receipts for laboratory fees;
c. Receipts for laboratory records;
d. Charting of missing teeth for partial dentures; and
e. Documentation that justifies the placement or replacement of dentures or partial dentures.

Laboratory and Professional Fees for Dentures/Partial Dentures [Refer to WAC 388-535-1290(9)]

HRSA does not pay separately for laboratory and professional fees for dentures and partial dentures. However, HRSA may partially reimburse for these fees when the provider obtains prior authorization and the client:

- Dies;
- Moves from the state;
- Cannot be located; or
- Does not participate in completing the dentures.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Complete Dentures (including 6 months post-delivery care)

- The HRSA dental program covers one maxillary and one mandibular denture in a 10-year period.
- No additional reimbursement is allowed for denture seat/delivery.
- D5110 through D5140 **require prior authorization from HRSA.**

D5110	**Complete denture – maxillary** (upper) **Requires Prior Authorization**	Yes	See Appendix
D5120	**Complete lower – mandibular** (lower) **Requires Prior Authorization**	Yes	See Appendix
D5130	**Immediate denture – maxillary** (upper) Appropriate radiographs must be submitted to HRSA. **Requires Prior Authorization**	Yes	See Appendix
D5140	**Immediate denture – mandibular** (lower) Appropriate radiographs must be submitted to HRSA. **Requires Prior Authorization**	Yes	See Appendix

Partial Dentures (including 6 months post-delivery care)

- D5211 and D5212 are covered for 1-3 missing anterior teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing any combination of 6 anterior and posterior missing teeth per arch or 4 or more anterior missing teeth per arch.
- D5211 through D5214 **require prior authorization from HRSA.**

D5211	**Maxillary partial denture – resin base** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	Yes	See Appendix
D5212	**Mandibular partial denture – resin base** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	Yes	See Appendix
D5213	**Maxillary partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	Yes	See Appendix
D5214	**Mandibular partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	Yes	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Lab and Professional Fees for Complete/Partial Dentures

D5899	**Unspecified removable prosthodontic procedure** Laboratory and professional fees may be paid for complete dentures or partial dentures if the patient: • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. **Requires prior authorization from HRSA.** **When requesting prior authorization, attach an invoice listing laboratory prescriptions and fees.**	Yes	See Appendix

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	See Appendix
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Repairs to Partial Dentures

D5610	**Repair resin denture base** Arch designation required.	No	See Appendix
D5620	**Repair cast framework** Arch designation required.	No	See Appendix
D5630	**Repair or replace broken clasp** Arch designation required.	No	See Appendix
D5640	**Replace broken teeth – per tooth** Use for initial tooth. Tooth designation required.	No	See Appendix
D5650	**Add tooth to existing partial denture** Tooth designation required.	No	See Appendix
D5660	**Add clasp to existing partial denture** Tooth designation required.	No	See Appendix

Denture Relining

- Relines are included in allowance for dentures if service is provided within first six months of placement of dentures.
- Reline of partial or full dentures is not allowed more than once in a 5-year period.

D5750	**Reline complete maxillary denture (laboratory)**	No	See Appendix
D5751	**Reline complete mandibular denture (laboratory)**	No	See Appendix
D5760	**Reline maxillary partial denture (laboratory)**	No	See Appendix
D5761	**Reline mandibular partial denture (laboratory)**	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Oral Surgery – Dentists

HRSA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page E.10); and
c) A hospital call, including emergency care, allowed one per day, per client, per provider.

Simple Extraction (includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	See Appendix
D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation required.	See desc.	See Appendix
D7220	**Removal of impacted tooth – soft tissue** Tooth designation required.	No	See Appendix
D7230	**Removal of impacted tooth – partially bony** Tooth designation required.	No	See Appendix
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation required.	No	See Appendix
D7241	**Removal of impacted tooth - completely bony with unusual surgical complications**	No	See Appendix
D7250	**Surgical removal of residual tooth roots (cutting procedure)**	No	See Appendix
HRSA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]			

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Adjunctive General Services

Unclassified Treatment

D9110	**Palliative (emergency) treatment of dental pain – minor procedure** • Emergency palliative treatment is: ✓ Covered only when no other definitive treatment is performed on the same day; and ✓ Covered once per client, per day. • A description of the treatment performed must be documented in the client's record. • Not allowed when performed on the same date as root canal therapy.	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Anesthesia

HRSA covers the following anesthesia services as follows:

General Anesthesia

- For treatment of adults who are eligible under the Division of Developmental Disabilities;
- For medically necessary oral surgery procedure codes listed in HRSA's Dental Billing Instructions, dated October 2003, pages F.5-F.15;

Conscious Sedation

- For treatment of adults who are eligible under the Division of Developmental Disabilities;
- For medically necessary oral surgery procedure codes listed in HRSA's *Dental Billing Instructions*, dated October 2003, pages F.5-F.15 and page E.35;

- HRSA covers the above anesthesia services when the anesthesia is administered by:

  - ✓ An oral surgeon;
  - ✓ An anesthesiologist;
  - ✓ A dental anesthesiologist;
  - ✓ A Certified Registered Nurse Anesthesist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH); or
  - ✓ A dentist who has a current conscious sedation permit or a current general anesthesia permit from DOH.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When billing for general anesthesia, show the actual beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

- HRSA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

$101.15 + [TIME UNITS X $20.23] = MAXIMUM ALLOWABLE FEE
Note: Every 15 minute increment or fraction equals 1 time unit.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
	• Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to HRSA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*). • Documentation of medical necessity must be kept in the client's file.		
D9220	Deep sedation/general anesthesia HRSA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(A General Anesthesia permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide HRSA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	See Appendix
D9241	Intravenous conscious sedation/analgesia **Conscious sedation with parenteral agents.** **(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix
D9248	**Non-intravenous conscious sedation** Conscious sedation with multiple oral agents. **(A Conscious Sedation permit is required to be on file with HRSA from the provider/performing provider.)**	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- Medicaid-eligible clients in nursing facilities may not be billed for services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.
- Mass screening for dental services of clients residing in a facility is not permitted.

D9410	**House/extended care facility call** Allowed once per day, per facility, per provider, limited to three calls.	No	See Appendix
D9420	**Hospital calls (includes emergency care)** **Allowed once per day, per client, per provider.** **Not covered for routine preoperative and postoperative visits.**	No	See Appendix

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Drugs

D9630	**Other drugs and/or medicaments** Use this code when billing for pharmaceuticals. Payable only when billed with either D9220, D9241, or D9248. HRSA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	See Appendix

Miscellaneous Services

D9920	**Behavior management** • Requires the assistance of **one additional dental professional staff** • A description of behavior management procedures performed must be documented in the client's record.	No	See Appendix

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Site of Service (SOS) Payment Differential

SOS pertains only to CPT™ oral surgery codes.

How are fees established for the professional services performed in the facility and non-facility settings?

Based on the Resource-Based Relative Value Scale (RBRVS) methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components (work, practice expense and malpractice expense). MAA uses the two levels of practice expense to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS MAF)** – Paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS MAF)** – Paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and Management codes, which specify the site of service within the description of the procedure codes; and
- Major surgical procedures that are generally only performed in hospital settings.

How will the site of service payment policy affect provider reimbursements?

Providers billing professional services will be reimbursed at one of two maximum allowable fees, depending on where the service is performed.

Does MAA reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments, one to the performing provider and another to the facility. The reimbursement to the facility includes the payment for resources. The NFS MAF includes the allowance for resources.

The professional FS MAF excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower of FS MAF to performing providers when the facility is also reimbursed eliminates duplicate payment for resources.

When are professional services reimbursed at the Facility Setting Maximum Allowable Fee?

Providers are reimbursed at the FS MAF when MAA also makes a payment to a facility. MAA will follow the Centers for Medicare and Medicaid Services' (CMS) determination for using the FS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes will be reimbursed at the FS MAF:

MAA Place of Service Code	CMS Place of Service Description
21	Inpatient Hospitals
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
31	Skilled Nursing Facility
32	Nursing Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility

When are professional services reimbursed at the Non-Facility Setting Maximum Allowable Fees?

The NFS MAF is paid when MAA does not make a separate payment to a facility. Services performed in a provider's office, client's home, facility or institution (listed in the following table) will be reimbursed at the NFS MAF. MAA will follow CMS's determination for using the NFS MAF, except when this is not possible due to system limitations.

Professional services billed with the following place of service codes are reimbursed at the NFS MAF:

MAA Place of Service Code	CMS Place of Service Description
11	Office*
12	Client's Private Residence
12	Adult Family Homes
25	Birthing Center
26	Military Treatment Facility
33	Custodial Care Facility
33	Boarding Homes (e.g., Assisted Living Facility, Enhanced Adult Residential Care Facility, Adult Residential Care Facility)
50	Federally Qualified Health Center
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

* Includes Neurodevelopmental Centers

Oral Surgery

CPT codes are billable only by oral surgeons.
Use the HCFA-1500 claim form to bill.

Assistant Surgeon

Assistant surgeons will be reimbursed at 20 percent of the maximum allowance for those procedures indicating "**Yes**" in the *Assistant Surgeon Allowed* column of the fee schedule. State in the description of service area on the claim form ("Description" area) if assistant at surgery.

Oral Surgery

A. Global surgery reimbursement includes the provision of the following services:

- The operation;
- Preoperative visits, in or out of the hospital, beginning on the day prior to surgery;
- Services by the primary surgeon, in or out of the hospital, during a standard 90-day postoperative period (0 to 10 days for minor surgery);
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; and
- All additional medical or surgical services required.

B. When surgical procedure(s) are carried out within the listed period for follow-up care of a previous surgery, the follow-up period continues concurrently to their normal terminations.

C. When multiple surgical procedures are performed on the same client and at the same operative session, total payment equals the sum of 100% of the global fee for the highest value procedure. Reimbursement for the second through the fifth surgical procedures is 50% of the global fee for each procedure code.

To expedite payment of your claim, bill all the surgeries for the same operative session on the same claim form.

POSTOPERATIVE VISITS ARE INCLUDED IN THE SURGICAL FEE.

Oral Surgeons may access the Oral Surgery Fee Schedule for Children and Adults within the Physician-Related Services Fee Schedule using this link.

http://maa.dshs.wa.gov/RBRVS/2005_Fee_Schedules/PhysJuly05FeeSchedule.xls

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- ✓ MAA requires providers to bill known third parties for services. See page F6 and/or WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

Refer to MAA's General Information Booklet, Section K, for instructions on how to correct any billing problems you experience (e.g., Adjustments/Rebillings).

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary charge.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

How do I bill for clients eligible for both Medicare and Medicaid?

Medicare does not cover dental procedures. **Surgical** CPT procedure codes 10000-69999 must be billed to Medicare first. After receiving Medicare's determination, submit a claim to MAA. Attach a copy of the Medicare determination.

When can I bill an MAA client? [Refer to WAC 388-502-0160]

1. A provider may not bill, demand, collect, or accept payment from a client or anyone on the client's behalf for a covered service. The client is not responsible to pay for a covered service even if MAA does not pay for the service because the provider failed to satisfy the conditions of payment in MAA billing instructions, in chapter 388-502 WAC, and other chapters regulating the specific type of service provided.

2. The provider is responsible to verify whether the client has medical coverage for the date of service and to check the limitations of the client's medical program.

3. A provider may bill a client only if one of the following situations apply:

    a. The client is enrolled in medical assistance managed care and the client and provider comply with the requirements outlined in WAC 388-538-095, "Scope of care for managed care enrollees;"

    b. The client is not enrolled in medical assistance managed care, and the client and provider sign an agreement regarding payment for service. The agreement must be translated or interpreted into the client's primary language and signed before the service is rendered. The provider must give the client a copy and maintain the original in the client's file for department review upon request.

        The agreement must include each of the following elements to be valid:

        i. A statement listing the specific service to be provided;
        ii. A statement that the service is not covered by MAA;
        iii. A statement that the client chooses to receive and pay for the specific service; and
        iv. The client is not obligated to pay for the service if it is later found that the service was covered by MAA at the time it was provided, even if MAA did not pay the provider for the service because the provider did not satisfy MAA's billing requirements.

    c. The client or the client's legal guardian was reimbursed for the service directly by a third party (see WAC 388-501-0200);

d. The client refuses to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill insurance for the service. This provision does not apply to coverage provided by MAA. [Medical Assistance is not insurance.];

e. The provider has documentation that the client represented himself/herself as a private pay patient and not receiving Medical Assistance when the client is already eligible for and receiving benefits under an MAA medical program. The documentation must be signed and dated by the client or the client's representative. The provider must give a copy to the client and maintain the original documentation in the patient's file for department review upon request. In this case, the provider may bill the client without fulfilling the requirements in subsection 3.b. regarding the agreement to pay. However, if the patient later becomes eligible for MAA coverage of a provided service, the provider must comply with subsection 4 of this section for that service.

f. The bill counts toward a spenddown liability, emergency medical expense requirement, deductible, or copayment required by MAA;

g. The client received medical services in a hospital emergency room for a condition that was not an emergency medical condition. In such cases, a $3.00 copayment may be imposed on the client by the hospital, except when:

i. Reasonable alternative access to care was not available;
ii. The "indigent person" criteria in WAC 246-453-040(1) applies;
iii. The client was 18 years of age or younger;
iv. The client was pregnant or within 60 days postpregnancy;
v. The client is an American Indian or Alaska Native;
vi. The client was enrolled in a MAA managed care plan, including Primary Care Case Management (PCCM);
vii. The client was in an institution such as a nursing facility or residing in an alternative living facility such as an adult family home, assisted living facility, or boarding home; or
viii. The client receives services under a waivered program such as community options program entry system (COPES) and community alternatives program (CAP).

4. If a client becomes eligible for a covered service that has already been provided because the client:

   a. Applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must:

      i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
      ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service;

   b. Receives a delayed certification (see footer on page G.1), the provider must:

      i. Not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and
      ii. Promptly refund the total payment received from the client or anyone on the client's behalf, and then bill MAA for the service; or

> ☞ **Note:** Many people apply for a medical program *AFTER* receiving covered medical services. The department may take as long as 45 to 90 days to process medical applications.
>
> If eligible, the client receives a DSHS Medical ID card dated the first of the month of application. The Medical ID card is *NOT* noted with either the "retroactive certification" or "delayed certification" identifiers. Providers must treat these clients as the "delayed certification" procedure described above, even if the patient indicated he or she was private pay on the date of medical service.

   c. Receives a retroactive certification (see footer on page G.2), the provider:

      i. Must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for any unpaid charges for the service; and
      ii. May refund any payment received from the client or anyone on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

5. Hospitals may not bill, demand, collect, or accept payment from a medically indigent, GA-U, or ADATSA client, or anyone on the client's behalf, for inpatient or outpatient hospital services during a period of eligibility, except for spenddown and under the circumstances described in subsection 3.g. of this section.

6. A provider may not bill, demand, collect, or accept payment from a client, anyone on the client's behalf, or MAA for copying or otherwise transferring health care information, as that term is defined in chapter 70.02 RCW, to another health care provider.

   This includes, but is not limited to:

   (a) Medical charts;
   (b) Radiological or imaging films; and
   (c) Laboratory or other diagnostic test results.

Third-Party Liability

For dental services for children and pregnant women, you may elect to bill MAA directly and MAA will recoup from the third party. If you know the third party carrier, you may choose to bill them directly. The client may not be billed for copays.

For all medical claims, you must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier code information is available on the DSHS-MAA web site at http://maa.dshs.wa.gov. The information can be used as an on-line reference, downloaded, or printed. If you do not have access to MAA's web site, call 1-800-562-6136 and request that a hard copy or disk be mailed to you.

What general records must be kept in a client's record?

[Refer to WAC 388-502- 0020]

In addition to the specific documentation required for the Dental Program that is listed throughout this billing instruction, enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ Radiographs, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the, examination, , treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

  MAA does not pay for the copying or otherwise transferring health care information to another health care provider. This includes, but it not limited to, medical charts, radiological or imaging films, and laboratory or other diagnostic test results. [Refer to WAC 388-502-0160(6)].

Medical justification is required for all procedures. Missing documentation in the client's record may result in payment recouped from the provider

Notifying clients of their rights (advance directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the ADA Claim Form

These instructions are based on the ADA Dental Claim Form, 2002.

MAA encourages the use of the 2002 version of the ADA form to expedited claims processing. However, if using older versions of the ADA claim form, enter the required quadrant and arch designations in the "Tooth Surface" field (field 28).

See sample claim forms, pages H6-H8.

General Information

- Include any required prior authorization number. Prior authorized claim originals must be completed and returned as the billing document.
- Send only one claim form for payment. If the number of services exceeds one claim form, a second form can be submitted. Please make sure that all necessary claim information (provider number, patient identification code, etc.) is repeated on the second form. Each claim form should show the total charges for the services listed.
- Use either blue or black ink only. **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers on claim form.
- These instructions only address those fields that are required for billing MAA.

Send your claims for payment to:

Division of Program Support
PO Box 9253
Olympia WA 98507-9253

Field Description

HEADER INFORMATION

2. **Predetermination/Preauthorization Number –** Place the required prior authorization number or EPA number in this field. Indicate the line(s) the number applies to.

PRIMARY PAYER INFORMATION

3. **Name, Address, City, State, Zip Code:** Enter the address for DSHS that is listed in the shaded box above.

OTHER COVERAGE

4. **Other Dental or Medical Coverage** – Check the appropriate response.

5. **Subscriber Name (Last, First, Middle Initial, Suffix)** – If different from the patient, enter the name of the subscriber.

6. **Date of Birth (MM/DD/CCYY)** – Enter the subscriber's date of birth.

8. **Subscriber Identifier (SSN or ID#)** – Enter the subscriber's SSN or other identifier assigned by the payer.

9. **Plan/Group Number** – If the client has third party coverage, enter the dental plan # of the subscriber.

10. **Relationship to Primary Subscriber** – Check the applicable box.

11. **Other Carrier Name, Address, City, State, Zip Code** – Enter any other applicable third party insurance.

PRIMARY SUBSCRIBER INFORMATION

12. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code** – If different from patient's (field 20), enter the legal name and address of the subscriber here.

13. **Date of birth (MM/DD/CCYY)** –If different from patient's, enter the subscriber's date of birth.

15. **Subscriber Identifier (SSN or ID#)** – Enter the SSN or other identifier assigned by the payer.

16. **Plan/Group Number** – Enter the subscriber's group's Plan or Policy Number.

17. **Employer Name** – Enter the name of the subscriber's employer.

PATIENT INFORMATION

18. **Relationship to Primary Subscriber** – Check the appropriate box.

20. **Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code** – Enter the client's legal name, address, and **Patient Identification Code (PIC)**. MAA identifies clients by this code, not by their name. This alphanumeric code is assigned to each MAA client and consists of:

- First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (or fewer if the name is less than five letters).
- Alpha or numeric character (tiebreaker).

21. **Date of Birth (MM/DD/CCYY)** – Enter the client's date of birth.

23. **Patient ID/Account #:** If you wish to use a medical record number, enter that number here.

RECORD OF SERVICES PROVIDED

Each service performed must be listed as a separate, complete one-line entry. **Each extraction or restoration** must be listed as a separate line entry.

If billing for removable prosthodontics, missing teeth must be noted on the tooth chart.

24. **Procedure Date (MM/DD/CCYY)** Enter the six-digit date of service, indicating month, day, and year (e.g., October 1, 2003 = 100103).

25. **Area of Oral Cavity** – If the procedure code requires an arch or a quadrant designation, enter one of the following:

01	Maxillary area
02	Mandibular area
10	Upper right quadrant
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

If you are using a claim form that does not include this column, enter one of the above codes in the tooth surface column (field 28).

27. **Tooth Number(s) or Letter(s)** – Enter the appropriate tooth number, letter(s):

- 01 through 32 for permanent teeth
- A through T for primary teeth

28. **Tooth Surface** – Enter the appropriate code from the list below to indicate the tooth surface worked on. Up to **five codes** may be listed in this column:

B =	Buccal
D =	Distal
F =	Facial
I =	Incisal
L =	Lingual
M =	Mesial
O =	Occlusal

29. **Procedure Code:** Enter the procedure code from this fee schedule that represents the procedure or service performed. The use of any other procedure code(s) will result in denial of payment.

30. **Description of Services** - Give a brief written description of the services rendered. When billing for general anesthesia, enter the actual beginning and ending time. If billing for anesthesia, enter *only* the total # of minutes on the claim. To indicate a payment by another plan, write "insurance payment" in the description area and the amount in field 31. Attached the insurance EOB to the claim.

31. **Fee** - Enter **your usual and customary fee** (not MAA's maximum allowable rate) for each service rendered.

33. **Total Fee –** Total of all charges.

MISSING TEETH INFORMATION

34. Place an "X" on each missing tooth.

REMARKS

35. **Remarks** - This field may be used for justification for the services rendered, the name of any referring provider or facility, or the name of any provider who administered anesthesia.

Example of Remark: *"Jane Doe, CRNA administered anesthesia."*

ANCILLARY CLAIM/ TREATMENT INFORMATION

38. **Place of Treatment** – Check the applicable box and enter one of the following codes to show the place of service at which the service was performed:

Office	**11**	dental office
Hosp	**21**	inpatient hospital
	22	outpatient hospital
	23	hospital emergency room
ECF	**32**	nursing facility
	31	skilled nursing facility
	54	intermediate care facility/mentally retarded
Other	**12**	client's residence
	24	professional services in an ambulatory surgery center
	03	school-based services
	50	federally qualified health center
	71	state or public health clinic (department)

39. **Number of Enclosures (00-99)** – Check the appropriate box. If you check *yes*, indicate how many Radiographs are enclosed.

Note:

- Do not send Radiographs when billing for services.
- Radiographs are necessary only when prior authorization is being requested.
- Please write "Radiographs enclosed" on the mailing envelope and mail to the Program Management and Authorization Section (see "Authorization" in either Section D or Section E for address.)

40. **Is Treatment for Orthodontics?** – Check appropriate box.

41. **Date Appliance Placed (MM/DD/CCYY)** – This field **must be completed** for orthodontic treatment.

43. **Replacement of Prosthesis?** – Check appropriate box. If "yes," enter reason for replacement in field 35 (Remarks).

44. **Date Prior Placement (MM/DD/CCYY)** – Enter appropriate date if "yes" is check for field 43.

45. **Treatment Resulting from:** Check appropriate box.

46. **Date of Accident (MM/DD/CCYY)** – Enter date of accident.

BILLING DENTIST OR DENTAL ENTITY

48. **Name, Address, City, State, Zip Code** – Enter the dentist's name and address as recorded with MAA.

49. **Provider ID** – Enter the provider number assigned by MAA when you signed your Core Provider Agreement. It is the same seven-digit number that appears on the MAA Remittance and Status Report in the ***Provider Number*** area at the top of the page. It is this code by which providers are identified, not by provider name. **Without this number, your claim will be denied.**

52. **Phone Number –** Enter the billing dentist's phone number.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. **Provider ID** – Enter the performing provider number if it is different from the one listed in field 49. If you are a dentist in a group practice, please indicate your unique identification number and/or name.

56. **Address, City, State, Zip Code** – If different than field 48, enter the treating dentist's information here.

57. **Phone Number –** If different from field 52, enter the treating dentist's phone number here.

ADA Dental Claim Form

SAMPLE

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

JS030993SMITHA
SMITH, JOHN A

21. Date of Birth (MM/DD/CCYY) 3/9/03 | 22. Gender ☒M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	100103					D0120	Periodic Oral Exam	50.00
2	100103					D1120	Prophy - Child	30.00
3	100103					D1203	Fluoride	20.00
4	100103			19	O	D2140	1 Surface Amalgam	80.00
5	100103	10				D1510	Space Maintainer	100.00
6								
7								
8								
9								
10							Insurance Payment	200.00

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	80.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature | Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID 5310000 | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Procedures (00 to 99) Radiographs(x) | Oral Surgery | Models

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) | Date

54. Provider ID 5999999 | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

ADA Dental Claim Form

SAMPLE

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination / Preauthorization
☐ EPSDT/ Title XIX

2. Predetermination / Preauthorization Number
491000000

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
JS050133SMITHA
SMITH, JOHN A

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	101503					D5130	Immediate Maxillary Denture	500.00
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33 Total Fee	500.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature | Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) 11
☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Procedures (00 to 99) Documentation(s) | Oral Image(s) | Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID
5310000

50. License Number

51. SSN or TIN

52. Phone Number ( ) –

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) | Date

54. Provider ID

55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( )

58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) J516, J517, J518, J519

ADA Dental Claim Form

SAMPLE ORTHODONIC CLAIM FOR SEVERE MALOCCLUSION CLAIM WITH AUTHORIZATION

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination / Preauthorization
☐ EPSDT/Title XIX

2. Predetermination / Preauthorization Number
481000000

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
JS101189SMITHA
SMITH, JOHN A

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	100103					D8660	Orthodontic Case Study	200.00
2	110103					D8080	Initial Placement Severe Malocclusion	1,400.00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Please an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	1,600.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I authorize its use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature | Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID 5310000 | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) –

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☒ Provider's Office ☐ Hospital ☐ EDF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☒ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY) 100103

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) | Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) – | 58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519

How to Complete the HCFA-1500 Claim Form

**WHEN BILLING FOR ORAL SURGERY CPT CODES,
USE THE HCFA-1500 CLAIM FORM**

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated)HCFA-1500 claim forms.

- **Do not use red ink pens (use black ink for the circle "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or 'SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i. (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form.** MAA does not accept "continued" claim forms. If more that six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

Field **Description/Instructions for Completion**

1a. **Insured's I.D. NO.**: Required. Enter the MAA Patient (client) Identification Code (PIC) – an alphanumeric code assigned to each Medical Assistance client – exactly as shown on the client's DSHS Medical ID card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB Baby on Parent's PIC.

NOTE: The client's DSHS Medical ID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC, and enter indicator **B** in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing.).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2.*)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her Social Security Number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?**: Indicate *yes* or *no*. If yes, you should have completed *fields 9a. – d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report).

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

24B. **Place of Service**: Required. Use the appropriate place of service code as follows:

Office	**11**	dental office
Hosp	**21**	inpatient hospital
	22	outpatient hospital
	23	hospital emergency room
ECF	**32**	nursing facility
	31	skilled nursing facility
	54	intermediate care facility/mentally retarded
Other	**12**	client's residence
	24	professional services in an ambulatory surgery center
	03	school-based services
	50	federally qualified health center
	71	state or public health clinic (department)

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charges for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24H. **EPSDT Family Plan**: When billing the department for one of the EPSDT screening procedure codes, enter an **X** in this field.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered**: When required, put the name of the facility where services were performed.

33. **Physician's Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, *Address,* and *Phone #* on all claim forms.

P.I.N.:
This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH MARY J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 60 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 900 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 802.22 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 30 03	10 30 03	21		21451		802.22	60000					
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 60000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 60000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

JAMES STREET ORAL SURGERY
1234 JAMES STREET
ANYTOWN WA 98000

PIN# 5234123 GRP# 5014368

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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